Adventist HealthCare

1801 Research Boulevard, Suite 400 • Rockville, MD 20850
(301) 315-3030 • (301) 315-3000 FAX
www.AdventistHealthCare.com

VIA EMAIL AND FEDEX

May 29, 2009

Paul E. Parker
Chief, Certificate Of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Completeness Review Response
Washington Adventist Hospital
Matter No. 09-15-2295

Dear Mr. Parker:

With this letter we are submitting the required ten (10) copies of our response to the Completeness Questions regarding the above-referenced project, pursuant to the letter dated April 24, 2009.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as well as other applicants and those persons designated by the Health Facilities Coordination Office, as noted below.

Sincerely,

Christopher C. Hall
Senior Director Strategic Planning

cc: Ulder J. Tillman, M.D., MPH, Montgomery Co. Health Dept.
Ken DeStefano, Esq.
Howard Sollins, Esq.

1. Item 9 indicates that Commission staff will provide a separate spreadsheet on which the applicant will display current and proposed bed capacity by physical location. Please complete the attached spreadsheet for the existing hospital's bed capacity and the proposed hospital's bed capacity.

Applicant Response:

Please find a Chart for the existing hospital's bed capacity and proposed hospital's bed capacity at **Attachment 1**.

2. The response to Item 10.C.(1) indicates that title to the site is held by Adventist HealthCare, Inc. and the response to questions 10.C.(3) indicates that the site will be leased to Washington Adventist Hospital, Inc. ("WAH") at a cost of $500,000 per year with the expiration date and renew ability to be as required by HUD for FHA insurance. Please provide a detailed explanation of the purchase of the land including price, how the portion allocated to the hospital lease was calculated (the note on page 11 indicates a total land value of $10,500,000 with $7,100,000 assigned to the hospital lease), and HUD's role in the project with respect to lease terms.

Applicant Response:

The land was purchased in 2007 by Adventist HealthCare, Inc.(AHC) 48.8 acres of land was purchased for contemplated multiple uses (for an acute care hospital, for a senior living project, for medical office buildings, for structured parking, for a lifestyle center and for a potential future fire and rescue station and a center for spiritual life and health). AHC has worked with the Montgomery County Planning Board and Montgomery County Board of Appeals to properly plan for these uses. The $7,130,000 property value was based on development cost of the Hospital including the two (2) Parking Structures verse the total development cost of the whole property as presented in the site approval.

Rather than subdivide the land, it is appropriate for AHC to lease the land to WAH. The $500,000 land rent has been determined to be appropriate after consultation with locally knowledgeable real estate professionals. The term of the land lease will be whatever is required by HUD for the FHA insurance since FHA insurance is mortgage related and the land will be part of the security required by HUD. Based on information from our advisors, the land lease will likely have a term of 50 years.

3. Regarding Chart 1 (page 8), please submit separate Chart 1 information for the hospital building and for the parking garage. Since the itemized costs under Site Preparation Costs equal approximately $8,150,000, which is the total amount included in the project budget (page 10), specify the budget line item that includes each of the following: roads; utilities; jurisdictional hook-up fees; signs; and landscaping.

Applicant Response:

Revised Chart 1 can be found at **Attachment 2** and revised Project Budget can be found at **Attachment 3**. Roads, Utilities, jurisdictional hook-up fees are included the construction of

building line item 1 (a) (1). Signs are included in Other Capital Costs, line item 1 (c) (4). Landscaping is included in Site Preparation Costs, line item 1 (a) (4).

4. Please provide in one narrative summary, as detailed and specific a description of the post-project Takoma Park campus as can be provided at this time, identifying what facilities and/or features will be included, and indicating whether decisions by WAH on inclusion of these facilities and features are firm or tentative. Has WAH developed analyses and projections of the cost involved in implementing its Takoma Park campus plans? If so, please provide these analyses and projections. Has WAH performed any market feasibility or financial feasibility studies relating to post-project development and/or redevelopment of the Takoma Park campus? If so, please provide copies of these studies. What policies with respect to access for the indigent and charity care will be used by health care providers on the Takoma Park campus?

Applicant Response:

Washington Adventist Hospital is in the mist of establishing a reuse plan for the Takoma Park campus creating a "Village of Health and Wellbeing." The vision for the new Takoma Park campus continues our commitment to a community we have served for more than 100 years. At this time, WAH has not developed full analyses and projections of the costs, market feasibility or financial feasibility studies. Being congruent to our long standing commitment to the community and our mission, the reuse of the Takoma Park campus intends to provide services for all residents including indigent and charity care.

The currently WAH campus consists of 425,000 square feet of buildings on a 13- acre plot of land. The re-use plan calls for the demolition of approximately 100,000 square feet of space that is deemed too old and to costly to rehabilitate. When the re-use project is complete, the Takoma Park campus will include numerous healthcare related services, social services, and educational services for the community. Other considerations for inclusion in the new "village of health and well-being" include a health science affiliation with Columbia Union College.

The 13-acre site where the existing hospital is located is very congested, difficult to access, and too small to allow expansion to provide physicians with needed offices and other healthcare related facilities. Approximately 31 percent of the patient rooms in the hospital are private. The other 69 percent of the rooms are semi-private which causes numerous problems with the rise community acquired infectious diseases. The space design is inefficient and does not meet any of the current nation wide health care standards. The two-lane residential roads that serve as access to the Takoma Park site make the hospital complicated to reach for both emergency and private vehicles. Parking is also very limited for both patients and staff.

The new vision for the Takoma Park campus is being developed from ideas received during more than 200 personal interviews conducted with staff, physicians and community members over the past 24 months. The continued use of the Takoma Park campus, along with the hospital's relocation, will provide additional points of health care access for all the communities WAH serves.

Based on the feedback received and the community's needs and interests, the plan may include the following list of health-care, educational, and support components. Many of the services listed below maybe developed in collaboration with other entities:

- Emergency Medical Care or Urgent Medical Care
- Adventist Rehabilitation Hospital of Maryland
- Clinic for low-income residents
- Primary Care and other physician services
- Integrative Medicine
- Dialysis, Outpatient Imaging, and Diagnostic Services
- Fitness and Wellness Center
- Clinical Trial Beds[1]
- Behavioral health services
- Assisted living facilities
- Comprehensive inpatient and outpatient rehabilitation services
- Health education, research and training
- Immigration assistance center
- Assistance for foreign trained physicians and allied health care workers
- Storage space for medical records, etc.
- Senior Health Services
- Space for Non-Profit Community Organizations
- Eatery or Cafeteria Accessible to the Local Community

The following is a direct quote from Bill Robertson CEO of Adventist Healthcare,

"Washington Adventist Hospital has served the community for more than 100 years and we are committed to continuing the tradition of being an important community partner in Takoma Park and in the other communities we serve by providing residents with improved access to health care and health-care facilities which meet their needs, and by planning for the next 100 years."

The reuse of the WAH campus is critical to meet the needs of the ever growing healthcare requirements of the community that Adventist Healthcare Serves.

5. Please identify the person(s) or organization(s) that prepared the project cost estimate and describe the process used to prepare the estimate, including the basis for the inflation allowance estimate. When was the estimate included in the CON application prepared? Explain how the inflation estimate relates to the other capital cost estimates with respect to the time period coverage? What assumptions were made, in preparing the inflation estimate, with respect to the date on which construction of the project would commence and the date on which the project would be completed?

[1] These beds are for individuals who are participating in research studies but who do not need an overnight stay in a health care facility

Applicant Response:

Project cost estimating was coordinated by the Washington Adventist Hospital project management team along with the design team and several construction management teams and professional estimators. Project cost estimating occurred at multiple points during project development with the initial cost established upon completion of program development, followed by cost updates upon completion of schematic design (August 2008) and finally after a value engineering exercise (October 2008 thru March 2009). In addition to construction cost estimating activities, parallel processes were implemented to estimate costs and formulate budget components for major non-construction related capital requirements such as, medical equipment, information technology infrastructure, furnishings and fixtures, and kitchen requirements. These non-construction elements were handled using a comprehensive planning methodology based on existing conditions and current functional requirements reconciled against the design guidelines and program requirements for the replacement facility.

The inflation allowance estimate is derived by applying inflation rate projections for non-residential construction, medical equipment, and data and information technology pricing over 36 months which covers the period from April, 2009 (CON Submittal) to the mid-point of construction. The inflation allowance reflects market conditions specific to non-residential construction, medical equipment, and information technology components. The project management team consulted market condition and inflationary indices information provided by the "Associated General Contractors of America" and by "Premier Purchasing Partners, LP."

Final cost estimation details serving as the basis for project cost as submitted in the CON application were based on schematic estimates provided in October 2008 and validated in March 2009.

Participating individuals and entities are listed as follows:

Washington Adventist Hospital Project Management Team
Design Team

- RTKL Associates, Inc.
- Leach Wallace Associates
- Loiderman Soltesz Associates
- Parker Rodriguez
- The Traffic Group
- Cini Little International, Inc.

Construction Management

- Turner Construction
- Gilbane
- Driscoll Davis

Conceptual Estimator

- Faithful & Gould

Medical Equipment

- Premier Consulting Solutions, a division of Premier, Inc.

Furniture, Fixtures and Equipment

- Fox RPM Corporation

Information Technology

- RTKL Associates

6. Characterize the level of project design and specification in place when the project budget estimate was developed.

Applicant Response:

The project was completed through Schematic Design and a set of design documents were prepared for pricing. This included drawings of the project for Architectural and Landscape design as well as Civil, Structural, Mechanical, Electrical and Plumbing Engineering. It also included a short form specification in CSI format including divisions 2 through 16. A supplemental appendix included a Life Safety and Code Compliance Summary, LEED Review checklist and worksheets, Mechanical Concept Report, Mechanical Equipment cut sheets and Electrical cut sheets. A value engineering process ensued based on the Schematic Design pricing and supplemental Mechanical design documents were provided for alternative system pricing.

7. The label for line A.1.c(2) has been changed from Minor Movable Equipment to Furnishings. Please submit a revised Project Budget in the form specified in the application including the Lease Costs at the bottom of the form.

Applicant Response:

See Response to Question 3 with revised Chart 1 and Project Budget.

8. Please explain how the contingency allowance of $25,855,000 for the Hospital and $1,945,000 for the parking garage were calculated.

Applicant Response:

The contingency allowance for the Hospital ($25,855,000) is based on approximately 10% of the New Construction line items A.1.a.(1) – (6) and Other Capital Costs line item A.1.c.(4) plus 5% of Other Capital Costs Major/Minor Movable Equipment line item A.1.c.(1) and (2). The contingency allowance for the Parking garages ($1,945,000) is based on 5% of the New Construction line item A.1.a.(1) – (6).

9. Explain why the "Other" costs specified for Line A.1.c.(4) are included on this line rather than on one of the "New Construction" budget lines [(Line A.1.c(1) through (6)] or on the major/minor movable equipment lines [(Line A.1.c.(1) or (2)], such as the "Equipment Transferred from Old Hospital, Net." Explain the meaning of Net in this context.

Applicant Response:

Please see response to question 3 and the revised Project Budget for the Hospital. The appropriate "Other" costs (LEED Requirements, General Equipment) have been added to the "New Construction" budget line item A.1.a. (1) and (2).The term "net" means that the cost is net of accumulated depreciation, since this equipment was purchased and put in use by the existing WAH prior to opening of the new facility.

10. Please explain how capitalized construction interest was calculated for the hospital and for the parking garage. Specify the assumed interest rate the assumed construction period for each.

Applicant Response:

Please see the Assumptions at the bottom of Table 3 for the assumed terms of the underlying bond issue. The capitalized construction interest was allocated ratably between the hospital and the parking garage based upon the total capital cost (including inflation) for each project component.

11. Given that the primary source of financing for the project is proceeds from the sale of bonds, please explain why there is no interest income as a source of project funding.

Applicant Response:

The CON Project Budget presented of $68,768,000 of funded capitalized construction interest at net. Please refer to Item 9 of the Assumptions (included at the bottom of Table 3) for the respective interest rate assumptions.

The gross amount of interest expense and interest income funded through the bond issue as capitalized construction period interest are $81,030,000 ($415,540,000 Bond Issue, interest rate of 6.5% for 3 years) and $12,262,000, respectively.

12. Does the project budget include any expenditures related to facilities which will remain in operation at the Takoma Park campus?

Applicant Response:

The project budget does not include any expenditures related to facilities which will remain in operation at the Takoma Park campus.

13. Please provide a detailed description of the components of the Working Capial/Startup Costs/Transition Costs line item of $50,000,000. How much is budgeted for conventional working capital needs for the new facility? How much is budgeted for the move from Takoma Park to White Oak?

Applicant Response:

The CON Project Budget presents $50,000,000 for working capital and presents this $50,000,000 as coming from the existing hospital's net working capital. It assumes 64 days of net patient service revenue in patient accounts receivable, 66 days of certain operating expenses in accounts payable and 30 days of salary and benefit expenses in accrued salaries and benefits, and amounts for other items in current assets and current liabilities. These assumed days and amounts are consistent with current operations.

The CON Project Budget includes $2,500,000 for the move from Takoma Park to White Oak.

14. Does WAH currently have a written policy for the provision of information to the public concerning charges for its services? If so, please provide. If not, please briefly describe how the public is notified that such information is available for WAH and describe how requests for charge information are fulfilled.

Applicant Response:

While the hospital does not specifically have a policy on the release of charge information to the public, information regarding billing and expenses is provided to the public on the Washington Adventist Hospital web site:
http://www.adventisthealthcare.com/WAH/patientsvisitors/patients/expenses.aspx

Patient specific requests are handled when a patient is scheduled for an appointment or a procedure at the hospital. Insurance information is collected, verified, and if appropriate, an authorization is obtained. Patients are notified of their responsibility for co-pays and deductibles at time of admission or preregistration. At any time a patient may request specific information about the charges for their care. Patient Access staff can provide an estimate based on the type of procedure or service and the average rates over the past three months. Patients are notified that this is an estimate and that their experience may differ based on their own individual condition and the practice patterns of their physician.

15. Regarding the response to Project Review Standard 92), Charity Care Policy, please explain how the percentages in the first table on page 15 were calculated.

Applicant Response:

The data is the first chart on page 15 is sourced from the HSCRC data repository for the 12 months ended December 31, 2008. Charity care, bad debt and total uncompensated care dollars are reported as a percentage of total charges to all patients in that period.

16. Regarding the response to Project Review Standard (1), Geographic Accessibility, please submit the Montgomery County Special Exception and Site Plan approval especially as it relates to the commitment to provide an employee focused shuttle bus program. Has WAH analyzed or commissioned an analysis of how the proposed relocation will affect travel time to a hospital in the WAH patient catchment area, i.e., how many residents will experience a longer travel time with elimination of the WAH at the Takoma Park site? If so, please provide this information.

Applicant Response:

Special Exception and Site Plan documents specific to the employee focused shuttle bus program can be found at **Attachment 4**.

WAH has not commissioned an analysis of travel time to the new location. The Vision for Expanded Access (VFEA) is a multi-point initiative implemented by the hospital in 2005 to improve access to care for under-served communities and provide for improved facilities and services. The replacement and relocation of WAH along with the development of "The Village of Health and Well-Being" on the current Takoma Park campus are major VFEA elements that are designed to significantly enhance community access to primary and acute health care services.

17. The response to Project Review Standard (5), Cost Effectiveness, provides a detailed discussion of the challenges and limitations of the existing campus. However, the discussion of the alternative of undertaking major construction and renovations on the current campus was limited, especially with respect to project cost ($123,175,000 for phase one of a multi-phase plan). Please provide the following additional information and clarifications:
    a. Summarize the full scope of possible expansions and renovations on the current campus and provide an estimate of the full capital cost and potential operating cost implications of such an alternative;
    b. Submit a more detailed discussion of the limitations of such an alternative;
    c. Discuss the site selection process for the proposed location clearly documenting all of the alternatives considered and why the proposed site was selected;
    d. Explain how the proposed hospital will address the issue of surge capacity identified on page 24 of the application;
    e. Explain the "portal" approach to the layout of services referenced at the bottom of page 24.

Applicant Response:

a. An options decision grid can be found at **Attachment 5.**

The WAH and AHC leadership worked through a very thoughtful process to evaluate available options to modernize facilities and improve operations on the existing campus. In general terms, five possible options were evaluated against the current state and ran the gamut of address only deferred maintenance to fully

replace on a new campus. Four of the five options involved changes to the existing campus only. All current campus options have to contend with the aging 1950's building. This building, currently housing 100 patient beds, will require either full replacement or complete renovation at an estimated cost between $80M to $90M.

Further, in order to achieve facility and operational objectives, significant capital improvements are required to reorganize and modernize clinical services, add and develop substantial medical office space, and provide required parking capacity. Together with 1950's building capital requirements, the four current campus options are estimated to cost in the range of $134M, to simply address deferred maintenance and 1950's building issues, to $297M to provide 75% private patient rooms, add MOB and parking. Additionally, these estimated costs do not include disruption and impact to operations that would be the result of major capital improvements along with the elimination of 100 patient beds during the period to redevelop the 1950's building. Although un-quantified, this factor alone weighed heavy into the decision to replace the full hospital on a new campus.

In addition to evaluating the modernization options against cost, each option was scored against operational effectiveness criteria. The decision grid demonstrates that in spite of significant capital investment, current campus options cannot effectively address several fundamental issues such as accessibility, parking and physician office capacity, all private rooms, expansion capacity, aesthetics, service adjacency and the like. Because of this and significant disruption to operations, the current campus options were rejected.

b. See response to 17. a.

c. Along with real estate consulting assistance, the WAH and AHC leadership team worked through a very thoughtful process to evaluate potential sites for the replacement of the hospital. In total, five possible sites were evaluated according to specific criteria and were scored against a variety of important characteristics.

Of the five potential sites:

i. All but one were located in Silver Spring, Montgomery County, Md
ii. Only one was within a mile of the existing site
iii. Only one was available for purchase and full ownership
iv. Only one was available through private ownership

Although five potential sites were identified for the relocation and replacement of WAH, they were carefully evaluated and scored against the following twelve criteria:

1. Accessibility / Location (major interconnecting roadways)
2. Available Acreage (to accommodate full master plan & associated structures)
3. Purchase to Own (site control)
4. Zoning (proper zoning and entitlements)

5. Existing Public Transportation (bus, train)
6. Feasibility (ease of transaction)
7. Within Existing Primary Service Area
8. Within Montgomery County
9. Area Compatibility (harmony with surrounding development)
10. Ease of Development (site or other constraints)
11. Natural Setting for Healing Environment (close adjacency to natural elements (trees, water, gardens)
12. Access to Science and Technology Organizations(s) (proximity to FDA, U of MD, science and technology affiliates)

As demonstrated by the "Site Selection Decision Grid" at **Attachment 6**, the selected site (Site #5) scored well above the other four site options and is the only site that allowed for full site control through purchase and full ownership.

d. WAH leadership has been intentional around seeking master plan design solutions to address the issue of "surge capacity" in order to respond to regional public health emergencies. Project team members along with the design team have spent considerable time evaluating potential campus based solutions. In fact, various solutions involving the "North Parking Structure" have been evaluated programmatically according to specifications and requirements for "Portable Hospital Systems". Further, meetings have been held with the Fire Chief and staff of the Montgomery County Fire and Rescue Service to explore these options as well as the emerging "Ambulance Bus" system being developed by the area-wide Council of Governments representing Montgomery and Prince Georges Counties of MD, Fairfax County, VA, and the District of Columbia. Lastly, through its membership on the Montgomery County Healthcare Collaborative on Emergency Preparedness, WAH presented surge capacity concepts to the members and requested participation and input (minutes at **Attachment 7**).

e. The "portal" approach was abandoned from design and therefore this reference should be omitted

18. Regarding the response to Project Review Standard (6), Burden of Proof, please provide the following additional information and clarification:
    a. The response indicates that WAH proposes to construct 12 operating rooms ("ORs") but only finish 7 initially. The floor plans show 6 ORs. Please clarify and correct, as necessary, the narrative and/or the floor plans, as necessary; and the floor plans reflect a program for 12 operative procedure suites which includes one cystoscopy suite. Initial build-out will provide six surgical operatories and one cystoscopy suite.
    b. Please provide 5 years of historical utilization data for the ORs including numbers of both inpatient and outpatient cases and associated surgical minutes for each. Please provide an explanation of the methodology and assumptions used in projecting surgical case volume and operating room time.

Applicant Response:

a. The floor plans reflect a program for 12 operative procedure suites which includes one cystoscopy suite. Initial build-out will provide six surgical operatories and one cystoscopy suite
b. Please find at **Attachment 8** a matrix showing the historical utilization data for the ORs.

19. Response to Project Review Standard (7), Construction Cost of Hospital Space, please provide the following clarifications:
    a. Provide a detailed list of the extraordinary cost items excluded from the MVS analysis and explain why it is appropriate to exclude each item; and
    b. Do not include fitting out of the shell space in this analysis. Compare the MVS cost for the building that will be built or the components thereof to the actual cost of the project adjusted for costs that are not included in the MVS costs.

Applicant Response:

a) The cost items that were excluded from the MVS analysis and explanation can be found at **Attachment 15.**

b) not including fitting out of the shell space:

MVS Calculations to Build a Class A, Good Hospital in Montgomery County
January, 2009

	Unadjusted Costs	Extra. Costs	Total Costs
New Construction*	$189,175,000	$17,658,690	$171,516,310
Site Preparation	$6,700,000		$6,700,000
A/E & Consultant Fees	$15,300,000		$15,300,000
Permits	$526,000		$526,000
Net. Cap. Interest**	$15,370,000	$1,610,000	$13,760,000
TOTAL	$227,071,000		$207,802,310
TOTAL SQUARE FEET			603,748
		Cost/Sq. Ft.	$344.19

*includes fixed equipment.
**Capitalized Construction Interest Minus Earnings During Construction Period.
*** $17,798,000 Extra. Cost for New Constr., Site Prep., & A/E Fees.

20. Regarding the response to Project Review Standard (7), Inpatient Nursing Units, please detail how "DGSF" was defined in responding to this standard and elsewhere in the application.

Applicant Response:

The department area was determined by summing the interior room areas for each departmental unit, including all patient rooms, support spaces and family support rooms within that department. The tabulation excluded corridor circulation, stairs, elevators, shafts, utility rooms, structural columns, shear walls and exterior wall enclosure. As an example, below is the summary table for the 2North ICU/CCU Unit:

ROOM SCHEDULE BY DEP'T - ICU/CCU

Level	Department	Room Name	Area (SF)
2NORTH - ICU/CCU			
2North	Critical Care Unit	Ante	65
2North	Critical Care Unit	Ante	62
2North	Critical Care Unit	Ante	62
2North	Critical Care Unit	Ante	62
2North	Critical Care Unit	Ante	62
2North	Critical Care Unit	Ante	57
2North	Critical Care Unit	Central Monitor	268
2North	Critical Care Unit	Clean Supply	113
2North	Critical Care Unit	Clean Supply	140
2North	Critical Care Unit	Clean Supply	110
2North	Critical Care Unit	Clean Supply	127
2North	Critical Care Unit	Dictation	47
2North	Critical Care Unit	Equip. Stor.	140
2North	Critical Care Unit	Equip. Stor.	133
2North	Critical Care Unit	Family Consult	162
2North	Critical Care Unit	Family Waiting	274
2North	Critical Care Unit	Intensivist Office	102
2North	Critical Care Unit	Isolation	270
2North	Critical Care Unit	Isolation	265
2North	Critical Care Unit	Isolation	257
2North	Critical Care Unit	Isolation	258
2North	Critical Care Unit	Isolation	264
2North	Critical Care Unit	Isolation	258
2North	Critical Care Unit	Lockers	328
2North	Critical Care Unit	Medication	45
2North	Critical Care Unit	Medication	45
2North	Critical Care Unit	Medication	48
2North	Critical Care Unit	Medication	62

2North	Critical Care Unit	Nourishment Alcove	15
2North	Critical Care Unit	Nourishment Alcove	13
2North	Critical Care Unit	Nurse Station	350
2North	Critical Care Unit	Nurse Station	350
2North	Critical Care Unit	Nurse Station	328
2North	Critical Care Unit	Nurse Station	337
2North	Critical Care Unit	Office	96
2North	Critical Care Unit	Office	96
2North	Critical Care Unit	Office	94
2North	Critical Care Unit	Office	114
2North	Critical Care Unit	Office	96
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	283
2North	Critical Care Unit	Patient Room	279
2North	Critical Care Unit	Patient Room	284
2North	Critical Care Unit	Patient Room	285
2North	Critical Care Unit	Patient Room	289
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	270
2North	Critical Care Unit	Patient Room	295
2North	Critical Care Unit	Patient Room	292
2North	Critical Care Unit	Patient Room	285
2North	Critical Care Unit	Patient Room	285
2North	Critical Care Unit	Patient Room	284
2North	Critical Care Unit	Patient Room	285
2North	Critical Care Unit	Patient Room	285
2North	Critical Care Unit	Patient Room	271
2North	Critical Care Unit	Resp. Therapy	63
2North	Critical Care Unit	Resp. Work	70
2North	Critical Care Unit	Soiled Hold	96
2North	Critical Care Unit	Soiled Hold	96
2North	Critical Care Unit	Soiled Hold	133
2North	Critical Care Unit	Soiled Hold	99
2North	Critical Care Unit	Staff Lounge	404
2North	Critical Care Unit	Staff Tlt.	77
2North	Critical Care Unit	Staff Tlt.	77
2North	Critical Care Unit	Staff Tlt.	51

2North	Critical Care Unit	Staff Tlt.	50
2North	Critical Care Unit	Staff Tlt.	58
2North	Critical Care Unit	Supply Storage	132
2North	Critical Care Unit	Social Work Office	106
2North	Critical Care Unit	Social Work Office	102
2North	Critical Care Unit	Team Conf.	302
2North	Critical Care Unit	Team Conference	305
2North	Critical Care Unit	Workroom	101
		Total Area:	**15509**

21. Regarding the response to Project Review Standard (11), efficiency, please respond to the following:
    a. Provide a detailed explanation of why the project will result in an increase in FTE staff, and explain this projection with reference to the four efficiencies identified that would tend to reduce staffing requirements. What, if any, efficiencies are achieved by adding staff? And
    b. Respond to subsection (a) for each diagnostic and treatment service.

Applicant Response:

a. The efficiencies in staffing allow the overall increase in FTEs throughout the projection period to be modest. (What we meant by modest is less than what would have been expected in relationship to volume increases.) If we assume overall staffing is 70% variable with volume (and we used EIPDs as the volume statistic for other than 100% inpatient areas), the FTEs would have increased by approximately 13.7 FTEs by 2015 as compared to 2009; however, Table 5 shows an increase of 4.1 FTEs.
b. An allocation by service has not been assigned.

22. Regarding the response to Project Review Standard (14), Emergency Department Treatment Capacity and Space, please provide the following clarifications:
    a. Please provide a detailed description of the methods and assumptions used in projecting ED visit volume;
    b. How has the planned development of the urgent care center on the Takoma Park campus been factored into ED utilization projections?
    c. Explain why performance parameters such as ALOS in the ED, time to admit, and average turnaround time for diagnostic test results are expected to be in the high range;
    d. The comparison to the American College of Emergency Physician ("ACEP") guidelines indicates that observation/evaluation beds are located in the ED, but they are not clearly identified on the floor plans. Discussion at the Application Review Conference indicated that this element was removed form the projected. Therefore, the comparison to the ACEP guidelines should be revised accordingly.

Applicant Response:

a) The projections of ED visit volumes for the existing hospital ED were based on historical trends, and limited to 1% annual increases. Following the relocation to the White Oak site, we anticipate that ED visit volumes will modestly increase to 2% per year. We assumed that because the services and service area of the Hospital will not change through 2015, the modest projected increases would be due to: 1) growth in the projected population, 2) aging of the population, 3) improved geographic access to ED services in a new hospital, and 4) continued access to the Hospital ED through referrals and transfers from the proposed urgent care center on the Hospital's Takoma Park campus.
b) The planned development and operation of the Takoma Park urgent care center was considered a potential source of referrals and transfers to the Hospital's White Oak ED in the future. Because the features of this center have not yet been finalized, e.g., hours of operation, reimbursement status, EMS/ambulance protocols, etc., no specific projections of the number of referrals and transfers were included in the projections of Hospital ED visits at this time.
c) The performance parameters for the existing WAH ED are assumed to remain the same because the services and service area of the Hospital are not anticipated to change as a result of the relocation from the Takoma Park campus to the White Oak campus.
d) The construction of the proposed observation/evaluation beds in the WAH ED in the replacement Hospital will not be completed in the initial construction of the facility. Our revision to the ACEP Parameters is shown below:

Parameters Determining Size for Emergency Department	
Low Range Parameter	Applies to Washington Adventist Hospital
ALOS for all ED patients <2.5 hours	NO
Observation /Evaluation Beds located outside ED	YES
Time to admit <60 minutes after disposition	NO
Average turnaround time for diagnostic test results <30 minutes	NO
Less than 18% of patients are admitted to the Hospital	NO
Non-urgent patients outnumber urgent patients by more than 10%	NO
Less than 20% of patients are age 65+	NO
Minimal Need for offices or teaching spaces	YES
Imaging studies are not performed within the department	NO
No specialty components or departments	NO
Flight/trauma services support areas not included	YES
High Range Parameter	Applies to Washington Adventist Hospital
ALOS for all ED patients >3.5 hours	YES
Observation/evaluation beds will be located within the ED	NO
Time to admit >90 minutes after disposition	YES
Average turnaround time for diagnostic test results in >60 minutes	YES
More than 23% of patients are admitted to the Hospital	NO
Need for offices or teaching spaces, such as a university teaching hospital	NO
Imaging studies are performed within the department	YES
Specialty components or departments (pediatric ED, large number of psychiatric patients)	YES – psychiatric patients
Flight/trauma services support areas included	NO

23. Regarding the response to Project Review Standard (15), Emergency Department Expansion, please address the standard with respect to efforts at WAH to reduce use of its Emergency Department for non-emergency medical care and the management of existing emergency department capacity.

Applicant Response:

AHC's acute-care hospitals not only treat illness and disease, they also promote health and wellness, and help to improve the health status of the communities they serve. Through such programs as Cardiac Outreach, Oncology Outreach and Worksite Wellness, this service helps reduce healthcare costs for individuals and businesses, provides a broad range of community education programs and offers preventive programs and screenings that target special populations including children, the elderly, minorities, both women and men. More than 20,000 people have received education and screening services in 2008.

Of special note are the following health and wellness programs:

- The low-income breast cancer program that provides free mammography and education to more than 2,500 women annually. The Breast Cancer Screening Program at WAH helps low-income, uninsured women 40 years of age and older in Montgomery and Prince George's Counties, Maryland fight and defeat breast cancer. In partnership with the Montgomery County Women's Cancer Control Program and the State of Maryland Breast and Cervical Diagnosis and Treatment Program, the Breast Cancer Screening Program offers a continuum of care to patients including screenings and individual patient education, instruction on breast self-examinations and access to treatment. All patients diagnosed with breast cancer are case managed from diagnosis though treatment and beyond. Diagnosed patients are also recommended to the support group at WAH as well as the Look Good Feel Better Program.

- Special health initiatives for African-Americans, Latino-Americans and Asian--Americans

- Montgomery County's only sexual abuse and assault center located at Shady Grove Adventist Hospital

- The Cardiac & Vascular Outreach program for AHC is committed to supporting our mission by providing programming and screenings that will both educate, enable, and empower the people of our community to better understand and manage their risk factors and to make lifestyle changes with the goal of lowering their risks to heart disease. Cardiac outreach has touched many lives through our Heart Healthy Screening Programs. We strive to decrease and help eliminate the health disparities that exist among cultures in our communities, especially within the African American and Latino population.

- The Colorectal Cancer Screening Program, supported by the Cigarette Restitution Fund, provides education, outreach, and free screenings to eligible men and women residing in Montgomery County. The goal of the Colorectal Cancer Screening Program is to target men and women who are considered to be "at-risk" for colorectal cancer. This includes persons who are aged 50 and over, medically uninsured or underinsured, and who are low income. African Americans and Hispanic/Latinos have been identified as our main target populations as data reveal high colorectal cancer diagnosis rates in people of these minority groups. Program Coordinators for the screening program are continually out in the community promoting the program and providing outreach to faith-based settings (churches and synagogues), soup kitchens, area shelters, community centers, and work sites. It is our goal to increase awareness within the community of the cancer risk and the benefits of early detection and screening.

- Community Health Education uses a variety of strategies to improve the health status of the community as a whole by providing classes and programs that are both educational, as well as fun. We offered an array of classes from nutrition and self-improvement, as well as fitness classes, which include land and water activities. We also offered CPR and First Aid classes. In addition to providing community health classes, we actively participate in health fairs where we offer health screenings and flu shot clinics. As part of our mission to provide health awareness to the community, we established a number of partnerships in the area. We have added six additional sites where we provided flu shot clinics to the community. As a result of this collaboration, we were able to have a greater visibility in our community. The WAH service area has maintained a relationship with Riderwood where we have provided lectures on various health topics. Furthermore, we continue to strengthening our relationship with the Cancer Project and offered free nutritional classes to our community.

Address the Needs of Everyone. AHC's pioneering Center for Health Disparities, assisted by its Blue Ribbon Advisory Panel of community leaders, has three areas of focus: increased services for underserved populations; a research program to identify and promote best practices of healthcare for the underserved; and an education initiative to improve the ability of caregivers to provide quality care to those populations. Progress continues on a number of the panel's recommendations including an annual health disparities report card, a Maternal Services Center, a Patient Advocacy Program/Linguistic Access and Disparities Awareness Program, and cultural training programs for physicians and staff.

Engage the Community. AHC provides extensive educational and clinical opportunities through partnerships with 29 universities and specialty schools. Of special note is the relationship with Montgomery College for nursing students to do their clinical rotations. Most recent data from 2008 show that four AHC facilities (WAH, Shady Grove Adventist Hospital, Adventist Rehabilitation Hospital of Maryland and Potomac Ridge Behavioral Health) provided clinical rotations for 163 nursing students.

In addition to what is discussed above, AHC's Health and Wellness Department also collaborates with multiple organizations including Adventist Community Services, American Cancer Society, American Heart Association, American Lung Association, Avon Foundation, Susan G. Komen

Foundation, Montgomery County Health and Human Services, Montgomery County Fire and Rescue, Health Kids Campaign, Sister to Sister Foundation and GROWS (Grass Roots Organizations for Well-being of Seniors). These partnerships help improve community health and wellbeing. Other specific partnership examples include:

- Partnering with Mary's Center for Maternal and Child Care at its new primary care center in the Long Branch area of Montgomery County. Mary's Center, with 20 years of experience in serving the indigent in Washington, demonstrates how improved access to family medical care, coupled with sensitivity to culture and language, lead to healthy families and safer communities.

- Partnering with MobileMed in the operation of mobile clinic sites and the development and recent fixed-site clinics. Currently MobileMed provide clinic services at: Arcola Towers, Wheaton; Casa de Maryland, Silver Spring; Community Vision at Progress Place, Silver Spring; Crusader Church, Rockville, East Montgomery County Service Center, Silver Spring; Elizabeth House, Silver Spring; Gaithersburg/Ascension House, Gaithersburg; Gude Drive Men's Shelter, Rockville; Holly Hall, Silver Spring; Ibn Sina Clinic, Potomac; Kammsa Clinic, Gaithersburg; La Clinique L'A.M.I., Silver Spring; Lincoln Park Community Center, Rockville; Long Branch Community Center, Silver Spring; Pan Asian Volunteer Health Clinic, Silver Spring; Rockville Senior Center, Rockville; Shepherd's Table, Silver Spring; and Sophia House Women's Shelter/CBS, Rockville.

- Providing ancillary and other support services, including comprehensive health screenings, for patients treated at Mercy Health Clinic in Gaithersburg. Mercy Health Clinic is a free, non-profit, non-sectarian, community-based, primary healthcare provider serving uninsured, low-income adult residents of Montgomery County.

- Maternity clinics at WAH and Shady Grove Adventist Hospital as part of the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population.

- AHC partners with Casa de Maryland to provide health care and community services for the immigrant communities in Montgomery County and Prince George's County. The partnership includes the provision of primary medical care for uninsured residents, collaboration on ways to encourage immigrants to pursue a career in health care and a variety of other community services including language assistance and job training.

- AHC Health Ministry Outreach works with more than 19 community organizations and more than 48 congregations of all faiths, helping them through classes and health events to train and support Faith Community (Parish) Nurses who will directly provide support and care at the local community level.

Thus, as can be seen, we have been and will continue to be a valuable community asset and a major healthcare provider in the region, committed to fulfilling its mission and serving the general community. In addition to these partnerships and as discussed in the response to question 4 above, WAH proposes to develop a "Village of Health and Wellbeing" on the Takoma Park campus. The new Takoma Park campus establishes a promise to the community it has served for more than 100 years. Being congruent to our long standing commitment to the community and our mission, the reuse of the Takoma Park campus intends to provide services for all residents including indigent and charity care. Urgent care, integrative medicine and primary care as well as other uses are being proposed for the new campus.

24. Regarding the response to Project Review Standard (16), Shell Space, please provide the following clarifications:
    a. Characterize each distinct shell space component within the 7,575 total square feet of shell space identified at the top of page 42 as lower floor space that supports upper floors or space that does not support upper floors? Please provide the required net present value analysis for any shell space components falling within the latter category. Please provide the required information for all shell space components falling in the former category;
    b. Please justify the construction of ultimate space for 12 operating rooms. When does WAH project a need for 12 operating rooms? Show the basis for this need projection;
    c. The floor plans indicate that there is shell space on the top floor (6^{th}) which does not support upper floors and was not identified on page 42. Discussion at the Application Review Conference, April 23, 2009, indicated that the plans have changed and there is no shell space on the sixth floor. Therefore, the floor plans must be revised to eliminate the reference to shell space on the 6^{th} floor.

Applicant Response:

a) All of the shell space proposed for the WAH replacement hospital facility is located on lower floors that support upper floors.
b) The construction of 12 operating rooms in the replacement hospital is justified by the increased future utilization of surgical services at the replacement hospital brought about by the successful recruitment of community-based private practice surgeons. Currently, all recruitment efforts of surgical specialists and subspecialists are constrained by the features of the Hospital's current campus location and facilities. Unlike other hospital's serving residents of Montgomery and Prince George's Counties, WAH cannot offer the amenities necessary to attract orthopedic surgeons, neurosurgeons, general surgeons, obstetricians and gynecologists, and other surgical specialists because the Takoma Park campus has no vacant office space, limited parking, congested roadways, and old and out-of-date facilities. Hospital management has been approached by numerous community-based, private practice surgeons who have expressed strong interest in providing both inpatient and outpatient surgical services at the Hospital when it relocates from Takoma Park to White Oak. Prior to completing the construction of the replacement Hospital, a physician recruitment plan will be implemented with specific recruitment activities to be undertaken. For this reason, the White Oak campus of WAH will provide physician office space in one or more medical office buildings for newly recruited

surgeons, and the replacement Hospital has been designed to accommodate their future utilization with space for 12 operating rooms.

c) A revised set of drawings can be found at **Attachment 9**.

25. With respect to Standard .04(1), Need, provide the following additional information and clarifications:
    a. Submit a detailed description of the methodology used in projecting the obstetric case and patient day volumes. In projecting utilization, were fertility rates, historic and current obstetric utilization rates, and market shares considered? If yes, provide a detailed description of how these factors were considered. If not, explain why not;
    b. WAH noted a decline in utilization of the obstetric program in recent years and attributed this decline to the lack of modern facilities. Increased demand is projected for the new replacement hospital. Demonstrate that this projected increase in OB service demand has some basis in a larger post-relocation service are population, growth in population, and/or change in fertility rates or other changes in the service are or market share. Please project the impact of these changes on current providers of inpatient obstetric services with overlapping service areas.

Applicant Response:

a) Obstetrics volumes are projected to remain essentially flat for the remainder of the time WAH operates on the Takoma Park campus. Average length of stay is not expected to change due to changes in case-mix. We reviewed all of the statistical information concerning the likely future demand for obstetrical services in WAH's service area, including fertility rates in Montgomery and Prince George's Counties, historic and current obstetric utilization rates, and market shares. Shown below are the relevant statistics on natality for both Montgomery and Prince George's County.

Maryland Vital Statistics:
Montgomery County

	Mo. Co. Residents			Births in Mo. Co.		Births outside Mo. Co.			
YEAR	Births	Birth Rate	Fertility Rate	R & NR	Residents Only	DC	Other MD	Other States	TOTAL
2004	13,546	14.7	70.8	17,626	10,790	2,176	318	262	13,546
2005	13,507	14.6	71.4	18,234	10,917	2,012	302	276	13,507
2006	13,807	14.8	73.0	18,817	11,398	1,884	302	223	13,807
2007	13,843	14.9	74.3	19,087	11,453	1,840	308	242	13,843

Maryland Vital Statistics: PG. Co.

	PG. Co. Residents			Births in PG. Co.		Births outside PG. Co.			
YEAR	Births	Birth Rate	Fertility Rate	R & NR	Residents Only	DC	Other MD	Other States	TOTAL
2004	12,205	14.5	62.6	5,598	4,176	3,351	4,308	370	12,205
2005	12,545	14.8	65.1	5,633	4,279	3,178	4,695	393	12,545
2006	12,685	15.1	65.4	5,657	4,222	3,201	4,827	435	12,685
2007	12,802	15.4	67.8	5,233	4,025	3,185	5,175	417	12,802

Birth Rate: Per 1,000 population

Fertility Rate: Total births per 1,000 women ages 15-44.

b) This review assured us that in the future, the need for the obstetrics service at WAH will continue, and that WAH's replacement hospital should provide obstetrics services. However, just because the demand is there and will continue, WAH's ability to address that demand successfully will require both a new hospital facility and a successful strategy for recruiting additional private practice obstetricians to its medical staff. We are optimistic that the few obstetricians who remain on the WAH medical staff will continue to practice at WAH through CY 2012, and participate in the Medical Assistance and Maternity Partnership Program, despite the superior patient and physician amenities that are currently available at neighboring Maryland hospitals. As a practical matter, WAH must contend with the ongoing efforts of other hospitals to recruit its doctors before the White Oak WAH replacement project is completed. In CY 2008, the rapid decline in obstetrical admissions at WAH was wholly explained by the relocation of one sizeable obstetrical private group practice that was successfully recruited by Montgomery General Hospital. Market share shifts between WAH and its competitor hospitals are inevitably affected by such changes in the medical marketplace, and WAH recognizes that it is at a sizeable competitive disadvantage in its current Takoma Park location and in its current facility. For the WAH replacement hospital, we are similarly optimistic that obstetrics volumes will increase as projected in this CON Application as the number of obstetricians who choose to practice at the White Oak WAH campus grows. The projections of increased obstetrics volumes are justified by the increased future utilization of obstetrical services at WAH's replacement hospital brought about by the successful recruitment of community-based private practice obstetricians and gynecologists.

Currently, all recruitment efforts of obstetricians are constrained by the features of the Hospital's Takoma Park campus location and facilities. Unlike other hospitals serving residents of Montgomery and Prince George's Counties, WAH cannot offer the incentives necessary to attract obstetricians and gynecologists because the Takoma Park campus has no vacant office space, limited parking, congested roadways, and old and out-of-date facilities. As a result, our doctors leave, and our volumes decline. To reverse

this trend in WAH's obstetrics volumes, prior to completing the construction of the replacement Hospital, a physician recruitment plan will be implemented with specific and targeted recruitment activities to be undertaken. For this reason, the White Oak campus of WAH will provide physician office space in one or more medical office buildings for newly recruited obstetricians and the replacement Hospital has been designed to accommodate their future utilization with 30-bed obstetrics unit.

We modeled the demand for future Obstetrics services based on shifts in market share. In 2003, WAH had 2,516 Obstetrics admissions; it is projecting 2,667 Obstetrics admissions in 2015, a six percent increase over twelve years. If WAH's obstetrician recruitment efforts are successful following its move to a replacement hospital in White Oak, it will win back the market share it lost to other Maryland hospitals. The impact on any particular competitor hospital will be determined by which hospitals lose market share as private practice obstetricians relocate their practices and volumes to WAH. That impact cannot be determined quantitatively at this time.

26. Standards 1 through 6 apply to all applications and not just applicants for new services. Please address Standard 2, concerning the Maryland Perinatal System Standards.

Applicant Response:

The Maryland Perinatal System Standards require compliance with the essential requirements in thirteen categories for a Level IIB Perinatal Program. Washington Adventist Hospital (WAH) complies with all of the applicable standards, as discussed below.

Standard I. Organization.

1.1 WAH currently participates in the Maryland Perinatal System, including the submission of patient care data to the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS). Perinatal patients at WAH currently receive medical care commensurate with a Level IIB Perinatal Program, and WAH commits to providing the resources necessary to support the Level IIB Perinatal Program in the replacement hospital.

1.2 WAH is licensed by the DHMH as an acute care hospital

1.3 WAH is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

1.4 WAH is not seeking Certificate of Need approval for a Neonatal Intensive Care Unit in this application.

1.5 WAH, through capital and non-capital expenditures, maintains equipment and technology as described in the standards to support a level IIB program.

1.6 and 1.7 WAH does not intend to receive maternal and neonatal air transports.

Standard II. Obstetrical Unit Capabilities.

2.1 WAH has developed the capability of providing uncomplicated and complicated obstetrical care. Written policies have been developed to address: 1) unexpected obstetrical care problems, 2) fetal monitoring, 3) initiating a cesarean delivery within 30 minutes of the decision to deliver, and 4) selection and management of obstetrical patients at a maternal risk level appropriate to its capability.

2.3 WAH has developed a written plan for initiating maternal transports which are appropriate for a Level IIB Perinatal Center.

2.4 WAH does not accept maternal transports from other institutions, and has therefore not developed a written protocol for the acceptance of such transports.

Standard III. Neonatal Unit Capabilities.

3.1 WAH has developed the capability of providing uncomplicated and complicated neonatal care. Written policies address: 1) resuscitation and stabilization of unexpected neonatal problems according to the NRP guidelines, and 2) selection and management of neonatal patients at a neonatal risk level appropriate to its capability as a Level IIB Perinatal Center.

Standard IV. Obstetrical Personnel.

4.2 A physician Board-certified in obstetrics and gynecology is a member of the WAH medical staff and has responsibility for obstetrical services.

4.3 WAH does not accept maternal transports, and therefore does not have a Board-certified or candidate for Board-certification in maternal-fetal medicine.

4.4 WAH has developed an agreement with a MFM group to provide consultation services to WAH 24 hours/day.

4.5 WAH does not accept maternal transports, and therefore does not have a maternal-fetal medicine physician on the medical staff, in active practice and, if needed, in-house, urgently.

4.7 A board-certified physician is readily available to the delivery area at all times when a patient is in active labor at WAH.

4.9 A physician or nurse midwife is present at all deliveries at WAH.

Standard V. Pediatric Personnel.

5.2 A physician board-certified in pediatrics is a member of the WAH medical staff, has privileges for neonatal care, and has responsibility for the neonatal unit services.

5.5 NRP trained professionals with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation are immediately available to the delivery and neonatal units at WAH.

5.6 A physician with pediatric training beyond post graduate year two, a nurse practitioner or physician assistant with privileges for neonatal care is immediately available at WAH when an infant requires Level II neonatal services such as assisted ventilation, FiO2> 40%, or cardiovascular support.

5.7 A physician with pediatric training beyond post graduate year two, a nurse practitioner or physician assistant with privileges for neonatal care is readily available at WAH 24 hours a day. There are personnel in-house qualified to manage a neonatal emergency at all times.

5.8 An agreement between WAH and a Neonatology group has been made that provides that a physician board-certified or an active candidate for board certification in neonatal-perinatal medicine is available to be present in-house within 60 minutes.

5.9 WAH has a written pediatric cardiology and pediatric surgery consultation and referral agreements in place prior to commencing obstetrics services.

5.10 WAH has on staff an ophthalmologist with experience in neonatal retinal examination.

Standard VI. Other Personnel.

6.1 An anesthesiologist is available at WAH so that cesarean deliveries may be initiated within 30 minutes of the decision to deliver.

6.2 A physician board-certified or an active candidate for board-certification in anesthesiology is readily available to the delivery area at WAH when a patient is in active labor.

6.4 Neonatal surgery is not performed at WAH.

6.5 WAH does not provide critical interventional radiology services for obstetrical or neonatal patients. Patients who require these services are transferred to Shady Grove Adventist Hospital.

6.6 WAH has obstetric and neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal and/or neonatal disease and its complications.

6.7 WAH has a registered dietician or other health care professional with knowledge of and experience in adult and neonatal parenteral/enteral high-risk management on staff.

6.8 WAH has personnel with demonstrated competencies and protocols for lactation support.

6.9 WAH has a medical social worker with a Master's degree and experience in perinatal services on staff (i.e., a LCSW or Licensed Clinical Social Worker).

6.10 WAH has respiratory therapists skilled in neonatal ventilator management present in-house, 24/7 whenever a neonate requires respiratory support and is receiving assisted ventilation.

6.11 WAH has written consultation and referral agreements in place for genetic diagnostic and counseling services through arrangements with Shady Grove Adventist Hospital.
6.12 WAH refers appropriate newborns to a qualified neurodevelopment follow-up program.

6.13 WAH has registered nurses with knowledge and experience in obstetrical and neonatal nursing available to the obstetrical unit and neonatal units 24 hours a day.

6.14 WAH has nurses with special expertise in obstetrical and neonatal nursing identified for staff education.

6.16 WAH has on its administrative staff a registered nurse with Master's or higher degree in nursing or a health-related field.

6.17 WAH has developed and implemented a written plan for assuring nurse/patient ratios as per current Guidelines for Perinatal Care.

Standard VII. Laboratory.

7.1 WAH's laboratory is capable of reporting:

a) hematocrit, serum glucose, and blood gas within 15 minutes.

b) Complete blood count, micro blood chemistries, liver function tests, blood type and match, Coombs test, bacterial smear results, and coagulation studies (prothrombin time or PT, partial thromboplastin time or PTT, fibrinogen) within one hour.

c) Bacterial culture results within 48 hours, with sensitivities to follow.

d) Fetal scalp blood pH within five minutes (if fetal scalp blood pH testing is being utilized at the Hospital)

e) Serum magnesium within one hour.

f) Urine electrolytes within 6 hours.

g) Special amniotic fluid tests.

h) Group B streptococcus, hepatitis B surface antigen, RPR/VDRL, HIV, gonorrhea and Chlamydia maternal test results available before patient discharge.

7.2 Blood bank technicians are present in-house at WAH 24 hours a day.

Standard VIII. Diagnostic Imaging Capabilities.

8.1 Portable obstetric ultrasound equipment is present in the delivery area at WAH.

8.3 Portable x-ray equipment is available to the neonatal unit at WAH.

8.4 Portable head ultrasound for newborns is available to the neonatal unit at WAH.

8.5 CT equipment is available at WAH.

8.6 MRI equipment is available at WAH.

8.7 Neonatal echocardiography equipment and experienced technicians are available at WAH as needed with interpretation by pediatric cardiologists.

8.9 WAH refers or transfers mothers or neonates Shady Grove Adventist Hospital.

Standard IX. Equipment.

9.1 WAH has all of the listed equipment and supplies immediately available for existing patients and for the next potential patient.

9.3 WAH has fetal diagnostic testing and monitoring equipment for non-stress and stress testing, ultrasound examinations, and amniocentesis.

9.4 WAH has neonatal intravascular blood pressure monitors.

9.6 WAH has a full range of invasive maternal monitoring available to the delivery area, including equipment for central venous pressure and arterial pressure monitoring.

9.7 WAH has the appropriate equipment for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required for a Level IIB perinatal program.

Standard X. Medications.

10.1 Emergency medications, as listed in the Neonatal Resuscitation Program of the American Academy of Pediatrics/American Heart Association (AAP/AHA), are present in the delivery area and neonatal unit at WAH.

10.2 Antibiotics, anticonvulsants, surfactant, prostaglandin El and other emergency cardiovascular drugs are immediately available to the neonatal unit at WAH.

10.3 All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines, are present in the delivery area. An adult code blue cart is present on the WAH Labor and Delivery Unit.

10.4 Oxytocin, Methergine and Prostin/15M are present in the WAH delivery area.

Standard XI. Education Programs.

11.1 WAH requires perinatal clinical staff to take annual competency training and testing to meet a minimal set of competencies.

11.2 WAH provides continuing education programs for physicians, nurses, and allied health personnel on staff concerning the treatment and care of obstetrical and neonatal patients.

11.3 WAH does not accept maternal or neonatal primary transports.

Standard XII. Performance Improvement.

12.1 WAH has a multi-disciplinary continuous quality improvement program for improving maternal and neonatal health outcomes

12.2 WAH conducts internal perinatal case reviews to include all maternal, fetal, and neonatal deaths, as well as all maternal and neonatal transports.

12.3 WAH reviews the performance of its perinatal program, including trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process, and systems issues.

12.4 WAH participates with the Department of Health and Mental Hygiene and the Montgomery County Health Department, as well as voluntary efforts, to improve performance.

12.5 WAH participates in the collaborative collection and assessment of data with the Department of Health and Mental Hygiene and the Maryland Institute

for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.

Standard XIII. Policies and Protocols.

13.1 WAH has written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to the Level IIB services to be provided.

13.2 WAH has maternal and neonatal resuscitation protocols, the Code Blue Adult Protocol and the Code Blue Neonatal Protocol.

13.3 WAH has a written guideline for accepting neonates as "back transports" including criteria for accepting the patient and patient information on required care.

13.4 WAH has a written agreement with a licensed neonatal transport service.

13.5 WAH's staff credentialing process includes documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to a Level IIB perinatal program.

27. With respect to Standard .04(4) Medicaid Access, explain the relationship between the Medical Assistance program and the Maternity Partnership Program and respond to subsection (b) with specific regard to the Medical Assistance Program.

Applicant Response:

The Montgomery County Maternity Partnership Program contracts with county hospitals to provide prenatal and obstetrical care to indigent women who do not qualify for Maryland State Medical Assistance. This accounted 8,310 visits to our Women's Center and 633 deliveries at WAH in 2008. OB hospitalist services and clinic coverage in the Women's Center is provided under contract by ten physicians (of whom eight are obstetricians who participate in the MPP) who are on staff at WAH.

There are currently 30 physicians on staff in Obstetrics and Gynecology at Washington Adventist Hospital. 18 of those physicians performed 1,188 deliveries for Medical Assistance enrollees in 2008. All of these physicians will be invited to remain on the medical staff at the new facility location. WAH's commitment to the Maternity Partnership Program will continue when the Hospital moves to its new location.

28. Where are the emergency holding capabilities for psychiatric patients?

Applicant Response:

Four exam and assessment rooms are located within the emergency department, ambulance entrance side near the north-east corner.

29. Submit a written copy of discharge planning policies for psychiatric patients.

Applicant Response:

A copy of the written discharge planning policies for psychiatric patients is found at **Attachment 10.**

30. What is the basis for the projected rate of increase in psychiatric discharges and patient days? Identify all methods and assumptions used in projecting demand for psychiatric patient services.

Applicant Response:

We assumed that for both the existing Takoma Park (TP) PSA for adult inpatient psychiatric services, and a hypothetical White Oak (WO) service area, the demand for services would increase 1% per year. Average length of stay was assumed to remain constant because the types of care and types of patients are not likely to change at WAH during the forecast period. We have also assumed the continued availability of inpatient psychiatric services at other Maryland hospitals. The Hospital budgeted for 9,794 inpatient psychiatric patient days in CY 2009 for its 40-bed unit; the forecast for 2015 in the replacement hospital is for 10,397 patient days. (See TABLE 1., CON Application, p. 66.)

Shown below are the current and projected inpatient psychiatric discharges for Maryland hospitals serving the TP PSA. The balance of discharged patients will reside outside the PSA.

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

PSCH TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	1,059	39.4%	1,135	39.2%	6.70%
HX	37	1.4%	39	1.3%	5.13%
DCH	16	0.6%	17	0.6%	5.88%
MGH	587	21.8%	629	21.7%	6.68%
SH	230	8.5%	249	8.6%	7.63%
PGHC	293	10.9%	317	11.0%	7.57%
LRH	253	9.4%	274	9.5%	7.66%
Other Md.	216	8.0%	234	8.1%	7.69%
TOTAL	2,691	100.0%	2,894	100.0%	7.01%

31. With respect to the response to the "Need" Review Criterion, please provide the following:
    a. Readable service area maps in which zip code areas can be identified;
    b. What were the respective roles of Claritas and CR+K in preparing the historical and projected PSA population by age; and
    c. Are the 2000 populations for the PSA from the U.S. Census?

Applicant Response:

a) We have attached colored copies of the service area maps of Washington Adventist Hospital, and can make them available to you as electronic files as well.

b) For the PSA zip codes, CR+K obtained the totals by zip code from the Claritas data for the periods 2008 and 2013. The next step was to determine the total for Montgomery County from the Claritas data, which was then used to compute the weighting for each zip code in the PSA. These percentages were then multiplied by the Montgomery County total from the Maryland Department of Planning population dataset: 2009 Total Population Projections by Age, Sex and Race (2/5/09). Next, we used the Maryland population dataset to determine the distribution by age cohort and multiplied those percentages by the newly computed zip code total for the PSA zip codes. The age cohort distribution was then adjusted to reflect the change for the PSA zip codes as the aging would be different than that for Montgomery County. Once the projections were built up to 2020 we applied a constant growth factor from 2008 to 2020 to smooth out the projection.

c) It is our understanding that Claritas and the Maryland Department of Planning use the U.S. Census data as a basis for their estimates for 2000 population.

32. How will the service area of WAH change after it is relocated to White Oak? Specifically:
    a. What zip code areas in the Takoma Park WAH primary service area are not likely to be in the White Oak WAH primary service area, by service?
    b. What likely zip code areas in the White Oak WAH primary service area are not in the Takoma Park WAH primary service area, by service?
    c. What is the current and projected 2020 population of the Takoma Park WAH service area? What is the age and racial profile of the Takoma Park WAH service area?
    d. What is the current and projected 2020 population of the White Oak WAH service area? What is the age and racial profile of the White Oak WAH service area?

Applicant Response:

Before responding to the specific questions above, let us state this for the record: the management of Washington Adventist Hospital does not consider the relocation of WAH

from Takoma Park to White Oak to mean that the service area of the hospital will change in any significant way that can be accurately quantified and forecasted at this time. All of the analysis of the change in the PSA of WAH presented below are entirely hypothetical, and are based on educated guesses as to what in fact will occur when the hospital moves from Takoma Park to White Oak. We have presented these analyses because they were requested by the MHCC staff in order to complete the application for docketing, and our responses should be considered in that light to be highly speculative, at best.

With respect to inpatient psychiatric services, in particular, the geographically extensive PSA for this service (22 zipcode areas) suggests that even if WAH were to relocate to a zipcode area that is on the border of its current PSA, the future utilization of that service would not be changed. This is attributed to the fact that the inpatient psychiatric unit is the only locked unit on the east side of the County, and addresses that need alone among the other area hospitals for an obviously large and wide-ranging population. We hope that the relocation of the Hospital will only encourage those future patients who need the inpatient psychiatric services of WAH to avail themselves of this critical service, regardless of where they might reside.

Similarly, the PSA for Obstetrics unit is largely defined by the practice patterns of community obstetricians, who select their patient's hospital based on its proximity to their office practice, not necessarily on the location of their patients' residences. We know this to be a fact based on the loss of hundreds of future obstetrics patients at WAH as a result of the relocation of a sizable obstetrics group practice from WAH to Montgomery General Hospital in 2008. Our obstetrics patients didn't leave WAH's PSA, but their doctors certainly did. It is anticipated that additional community obstetricians will join the medical staff of WAH in the White Oak location due to its ability to provide on-campus office space, a feature that the Takoma Park campus of WAH cannot provide. It is not possible to determine in 2009 what zipcodes the patients of those obstetricians might be in 2013 and thereafter, but it is possible that they might include patients who do not live in the Obstetrics PSA of WAH today. To that extent, the PSA of WAH may change in response to the anticipated growth of WAH's OB service after 2012.

Finally, with respect to PSA for WAH's MSGA services, much of the change that might have taken place in the PSA following the move from Takoma Park to White Oak will be mitigated as a result of the commitment to redeveloping the Takoma Park campus as a continuing source of health and medical care services after 2012. Although it cannot be accurately quantified at this time, it is our expectation that many patients who will reside in the heart of the current MSGA PSA, e.g., Takoma Park, Langely Park and Silver Spring will continue to be admitted to WAH in White Oak for MSGA services because of their continuing utilization of the Takoma Park campus for primary care services, some of which will be provided in the proposed AHC-sponsored urgent care center. Should this center also provide emergency outpatient services, the change in the MSGA PSA between Takoma Park and White Oak for MSGA might be prove to be negligible.

a) Shown below are the zipcode areas that comprise the current service area of WAH, for FY 2008, defined as the first 60% of the Hospital's discharged patients, by service:

INPATIENT HOSPITAL SERVICE		
Obsetrics	MSGA	Psych
ZIPCODES OF WAH TP PSA		
20903	20783	20912
20906	20912	20910
20902	20782	20904
20904	20904	20902
20783	20901	20901
20912	20903	20783
20901	20910	20906
20782	20740	20903
20706	20902	20782
20910	20906	20770
20770	20705	20850
	20011	20740
	20737	20737
	20712	20781
	20706	20011
	20770	20874
		20895
		20712
		20877
		20784
		20706
		20020

The following zipcode areas that are listed above are "not likely" to be in the White Oak WAH primary service area, by service. We selected these zipcodes simply because they were located at the bottom of the WAH TP PSA listing, shown above:

INPATIENT HOSPITAL SERVICE		
Obsetrics	MSGA	Psych
ZIPCODES OF WAH TP PSA "NOT LIKELY" TO BE IN THE WO PSA		
20910	20011	20020
20770	20706	

b) The following zipcode areas that are listed below are "likely" to be added to the White Oak WAH primary service area, by service. We selected these zipcodes simply because they are geographically more proximate (closer) to the WAH WO location than the TP WAH location:

ZIPCODES OF WAH WHITE OAK PSA "NOT LIKELY" IN THE WAH TAKOMA PARK PSA
20866 Burtonsville -- MSGA, OB
20905 Silver Spring -- MSGA, OB, PSYCH
20707 Laurel, MSGA -- OB
20723 Laurel, MSGA -- OB
20759 Fulton, MSGA -- OB

c) The current population profiles for the FY 2008 Takoma Park WAH PSA and the hypothetical White Oak WAH PSA are attached. We have combined all of the zipcode areas for all three inpatient services in preparing these profiles. The current 2008 population of the Takoma Park WAH PSA is 724, 826, and is forecasted to increase to 814,174 in 2020, a 12.3% increase. The age profile indicates that the Takoma Park WAH PSA will become younger between 2008 and 2020, with relative decreases seen in the younger adult population (age 45-64) and significant increases in the older adult population (age 65+). Interestingly, the proportion of children and adolescents (age 0-14) in the PSA will remain proportionately the same at 20% in both periods. With respect to race, between 2008 and 2009, the proportion of Asians, Multi-racial, and other racial groups will increase, and the proportion of Blacks and Whites will decrease.

d) With respect to the current population profiles for the hypothetical White Oak WAH PSA, the current 2008 population of the White Oak WAH PSA is 798,120, and is forecasted to increase to 892,295, a 11.8% increase. The age profile indicates that the White Oak WAH PSA will also become older between 2008 and 2020, with relative decreases seen in the younger adult population (age 45-64) and significant increases in the older adult population (age 65+). As was the case for the TP WAH PSA, the proportion of Asians, Multi-racial, and other racial groups residing in the WO WAH PSA is expected to increase, and the proportion of Whites and Blacks are expected to decrease between 2008 and 2020.

TECHNICAL NOTE:

In order to prepare these demographic profiles, we identified the service area zip codes for each of the three inpatient services at WAH and combined them into one group. These were based on the Claritas data which provided us for population estimates for 2008 and forecasts for 2013 by age and race. In order to make forecasts to 2020 as requested, we used the distribution of the Maryland County data forecasts prepared by the Maryland Department of Planning by age cohort, and applied the 2020 age distribution percentages and growth forecasts by age cohort to the Claritas data.

33. With respect to the "Financial Viability" Review Criterion, please provide the following additional information and clarifications:
    a. Indicate when the Audited Financial Statement for 2008 is expected to be available and submit a copy when available. Is there an AHC financial statement that provides balance sheet and operational financial data for individual hospitals? If so, please provide.
    b. Document the availability of the $46,160,000 cash contribution to this project by summarizing the funds available for capital investments throughout the Adventist Health system and the planned uses of such funds through 2012;
    c. Provide documentation of the ability of WAH to raise the $25,000,000 in gifts included in the sources of funds; and
    d. Regarding Table 3, what is included in "Other Operating Revenue"?

Applicant Response:

a. The Audited Financial Statements for Adventist HealthCare are found at **Attachment 11**.

b. AHC was requested to document the availability of the cash contributions to the projects by summarizing funds available throughout AHC through 2012. As found in **Attachment 12,** the AHC Summary of Cash Flows Projection for 2009 – 2012 indicates the December 31, 2008 cash balance at nearly $154 Million and that with the additional borrowing of approximately $640 Million the approximate $819 Million of CON related projects and all other projects could be funded and cash still increase by $15 Million.

c. Our plan to raise $25 million for the relocated Washington Adventist Hospital is supported by a well-developed capital campaign plan for creating and developing the culture, staff and volunteer organization and infrastructure needed for successful execution.

There is strong professional and management support in place for the effort:

- Campaign counsel has been engaged and a detailed capital fundraising campaign plan developed. The firm selected for the campaign served as campaign counsel for the successful $100 million campaign by Florida Hospital (a large Seventh-day Adventist sister hospital located in Orlando, Florida); this campaign was completed last year as the amount raised was over the $100 million goal and was completed 15 months prior to the scheduled completion date.
- Washington Adventist Hospital has a strong, top-management commitment to the fundraising effort, supported by a highly engaged CEO and an enthusiastic executive team.
- Washington Adventist Hospital has served more than a million area patients and has been the primary hospital for thousands of physicians in its more than 100 operating years. Many of these constituents have expressed support for the new hospital and are likely to validate this support through financial giving.

Throughout 2009, the primary focus of the campaign effort will be on building the infrastructure and staff to create a high-performance Washington Adventist Hospital Foundation needed to drive a capital campaign.

To date, these activities have included:

- Creation of a sophisticated, multi-layered Case for Giving to articulate a compelling vision beyond simply that of a relocated hospital, including an overarching case and specific cases for each key component or aspect of the capital project;
- Specifying and hiring an expanded staff of development professionals, and support personnel. Recruiting is underway with six new development officers already hired;
- Creating a database and pipeline of prospective donors;
- Specifying and deploying a proven campaign management system developed specifically for major fundraising efforts and proven in the healthcare arena;
- Deploying a program of intensive training for the development staff in that system and other fundraising "best practices";
- Ensuring the ongoing monitoring of campaign progress by
    - Deploying a system of coaching and feedback meetings for development personnel;
    - Developing a metric-based approach to measurement and reporting of campaign progress, focusing on productivity and performance of development personnel;
- Beginning the building of a volunteer organization with as many as 300 community campaign volunteers to be organized into geographically focused and service-line focused fundraising boards within the service area; and
- Putting new information technology systems in place to support the campaign.

The question of whether or not to proceed with a capital campaign given the economic climate has been considered. In 2009 the plan is to devote much of the effort to pipeline development as well as building the staff and infrastructure to support the effort. Consequently, the current economic climate is not expected to affect the fundraising work in the immediate future.

d. Table 3 includes Other Operating Revenue projected based upon historical experience at the existing which includes revenue components for cafeteria, unregulated pharmacy, gift shop, grant income, rental and service income from Adventist Rehabilitation Hospital (for years 2009 through 2012) and other miscellaneous income.

34. Regarding the "Impact on Existing Providers" Review Criterion, please provide a detailed analysis supporting the claim that the proposed replacement hospital will have no impact on existing health care providers. This should include a projection of utilization (discharges, patient days) and revenues, by service, at the five Montgomery County hospitals, Prince George's Hospital Center, Laurel Regional Hospital and Doctors Community Hospital under the scenario in which WAH is relocated and under a scenario in which WAH is not relocated. These projections should be consistent with the projections provided elsewhere in the application for utilization at Takoma Park WAH and White Oak WAH.

Applicant Response:

Before proceeding with the projection of inpatient utilization and revenues by service, please note that the response provided to this Review Criterion on p. 78 of the CON application does not state that the replacement facility for WAH will have no impact on existing health care providers. Rather, we stated that the replacement hospital "will have no negative effects (emphasis added) on other providers, and will enhance the performance of the health care system for the benefit of all residents of its service area."

In response to Q. 32, we provided the existing PSA of WAH based on its actual Takoma Park (TO) location, and a hypothetical PSA based on its proposed White Oak (WO) location. Shown below is a summary of the two PSAs with respect to their population.

Age	Takoma Park PSA			White Oak PSA		
Cohort	2008	2020	% change	2008	2020	% change
0-14	107,884	121,618	12.7%	135,421	161,122	19%
15-64	381,593	384,909	.87%	451,312	509,937	13%
65+	66,313	108,027	62.9%	88,355	143,115	62%
Total	555,790	614,554	10.6%	675,088	814,174	20.6%

Source: Claritas, Inc.; CR+K.

To assess the potential impact of the proposed relocation of WAH from TP to WO on other Maryland hospitals, we examined the number and distribution of MSGA discharges from any Maryland hospital from both the Takoma Park PSA and the White Oak PSA for the FY 2008 period. For the scenario in which the Hospital moves from TP to WO, we estimated the changes that would occur to the PSA, and the resulting changes in utilization at other Maryland hospitals.

For the Takoma Park MSGA PSA, there were 29,909 total MSGA discharges to any Maryland hospital, of which 7,909 discharges were reported by WAH for a market share of 26%. The balance of MSGA discharges from the TP MSGA PSA were from Holy Cross Hospital (8524; 29%), Doctors Community Hospital (3,337; 11%); Montgomery General Hospital (3,105; 10%); Suburban Hospital (1,747; 6%); Prince George's Hospital Center (1,213; 4%), Laurel Regional Hospital (1,099; 4%) and All Other Maryland hospitals (2895; 10%).

As indicated in the CON Application (Attachment 6 and page 58), we projected a 2.2% annual increase in MSGA discharges among residents of the WAH PSA, and a 1% annual increase in MSGA volumes at WAH through 2012. This rate of increase would result in 35,597 total MSGA discharges among WAH TP PSA residents in FY 2016. If WAH's share of it PSA market were to remain the same as it was in FY 2008, than WAH would capture 9,255 of those MSGA discharges. In CY 2015, WAH is forecasted to have 14,863 MSGA admissions from all areas, meaning that its PSA discharges would be greater than 60% of its total. A more likely target for its PSA is 8,917 admissions.

Thus, even if WAH meets its targeted utilization, if the growth in TP PSA MSGA discharges is an accurate predictor of likely growth, then WAH's market share in CY 2015 will be less than FY 2008, or it will discharge fewer MSGA patients who reside outside the TP PSA. In either case, there is no likely negative impact on other Maryland hospital utilization based on WAH's projections of modest growth in MSGA utilization.

This suggests that if WAH were not to relocate from Takoma Park to White Oak, at best, it would continue to see a 1% increase in MSGA discharges through the forecast period of CY 2015, and, if market shares from the FY 2008 were to remain constant, that the other Maryland hospitals would see an increasing number of MSGA patients from among WAH TP PSA residents or residents of other areas.

As discussed in the CON Application itself, the volume projections for Hospital, including those projections for the 2009 through 2012 periods, assume that the replacement hospital facility will be CON-approved, built and open after 2012. Under the scenario in which the replacement hospital were not approved and built, the growth in WAH utilization at the TP site through 2015 would likely be less than forecasted. As discussed in the CON application and in response to Completeness Questions, management of WAH does not believe in the long-term potential of WAH on the TP campus.

Any reduction in utilization would also discourage any significant capital investment or physician recruitment for the WAH TP campus, and the long-term viability of the Hospital would certainly come into question. In the view of the management of WAH, the denial of the CON application to relocate the Hospital would signal that the State of Maryland would prefer to see WAH risk closure as volumes grew only slowly or remained at current levels, which could precipitate an even larger loss of market share, related to a decline in the number of private practice community physicians willing to admit their patients to WAH in the future.

In summary, under a scenario in which WAH is not relocated, the market for MSGA services would continue to grow through 2013 - 2015, but WAH's share of that market would likely continue to decline, perhaps, faster than the rate assumed in the projections provided in the CON Application for the 2009 through 2012 period, or it would see a decline in the share of patients from outside the PSA. Shown below are the forecasted volumes of MSGA cases at WAH under the two requested scenarios. The revenue impact on other hospitals under either scenario is positive.

Forecasted MSGA Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH Relocates to WO

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	7,909	26.4%	8,917	25.0%
HX	8,524	28.5%	10,216	28.7%
DCH	3,337	11.2%	4,043	11.4%
MGH	3,185	10.6%	3,862	10.8%
SH	1,747	5.8%	2,150	6.0%
PGHC	1,213	4.1%	1,515	4.3%
LRH	1,099	3.7%	1,379	3.9%
Other Md.	2,895	9.7%	3,517	9.9%
TOTAL	29,909	100.0%	35,599	100.0%

Forecasted MSGA Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH Remains in TP

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	7,909	26.4%	8,564	24.1%
HX	8,524	28.5%	10,266	28.8%
DCH	3,337	11.2%	4,093	11.5%
MGH	3,185	10.6%	3,912	11.0%
SH	1,747	5.8%	2,200	6.2%
PGHC	1,213	4.1%	1,565	4.4%
LRH	1,099	3.7%	1,429	4.0%
Other Md.	2,895	9.7%	3,567	10.0%
TOTAL	29,909	100.0%	35,596	100.0%

Source: Maryland Hospital Discharge Abstract.

Under the scenario in which WAH is relocated to WO, at least two types of impact would occur. First, consistent with projections provided in the CON application, before the relocation, the utilization of the Hospital would only grow 1% annually through 2012. This modest growth in discharges is fundamentally predicated on keeping all existing services of the Hospital operating until the replacement hospital facility opens, and minimizing the loss of admitting physicians and PSA market share in the current location.

Following the opening of the replacement Hospital in White Oak, we have forecasted a 2% annual increase in MSGA admissions, a 1% annual increase in psychiatric admissions, and 9% increase in obstetrics admissions through 2015. Because the forecasted annual increase in MSGA admissions at the Hospital is still less than the forecasted annual increase in TP MSGA PSA admissions of 2.2%, we do not believe that there will be any negative impact on the MSGA volume at other Maryland hospitals, if WAH's FY 2008 market share remains constant during the forecast period. Even if PSA market share increases, it is possible that there will be fewer admissions to WAH among residents of areas outside its PSA, in which case other Maryland hospitals that serve residents of those areas may see an increase in market share relative to WAH's.

Changes in the utilization for Obstetrics for WAH is projected based on the successful recruitment of community obstetricians, and increasing market share. As pointed out in the CON application and in the responses to Completeness Questions, the management of WAH believes that much of the decline in Obstetrics utilization at WAH in TP since 2007 is related to the competitive disadvantage of WAH's facility as perceived by community obstetricians and their patients, and the resulting migration of patients to other hospitals. It is hoped that the replacement hospital itself will increase the number of obstetrics and newborn cases at the hospital after 2012. Both Montgomery and Prince George's Counties have seen an increase in births over the past four years, as the chart below indicates. There is a growing market for Obstetrics services among residents of both Counties that WAH proposes to address.

Maryland Vital Statistics: Mo. Co.

	Mo. Co. Residents			Births in Mo. Co.		Births outside Mo. Co.			
YEAR	Births	Birth Rate	Fertility Rate	R & NR	Residents Only	DC	Other MD	Other States	TOTAL
2004	13,546	14.7	70.8	17,626	10,790	2,176	318	262	13,546
2005	13,507	14.6	71.4	18,234	10,917	2,012	302	276	13,507
2006	13,807	14.8	73.0	18,817	11,398	1,884	302	223	13,807
2007	13,843	14.9	74.3	19,087	11,453	1,840	308	242	13,843

Maryland Vital Statistics: PG. Co.

	PG. Co. Residents			Births in PG. Co.		Births outside PG. Co.			
YEAR	Births	Birth Rate	Fertility Rate	R & NR	Residents Only	DC	Other MD	Other States	TOTAL
2004	12,205	14.5	62.6	5,598	4,176	3,351	4,308	370	12,205
2005	12,545	14.8	65.1	5,633	4,279	3,178	4,695	393	12,545
2006	12,685	15.1	65.4	5,657	4,222	3,201	4,827	435	12,685
2007	12,802	15.4	67.8	5,233	4,025	3,185	5,175	417	12,802

Birth Rate: Per 1,000 population
Fertility Rate: Total births per 1,000 women ages 15-44.

The second type of impact would be if the existing PSA of WAH changes as a result of moving from TP to WO. Under this scenario, the distribution of patients coming to WAH from within the PSA would change. For example, it might be assumed that a higher proportion of MSGA patients from White Oak/Silver Spring (20904) and a smaller proportion of Takoma Park (20912) patients would be discharged from WAH at its WO location than at its TP location.

In order to estimate the impact on the current PSA of WAH resulting from the relocation from TP to WO, we hypothetically altered WAH's market share distribution of the 29,909 MSGA patients shown above by zipcode area, and redistributed the balance of the discharges to the other Maryland hospitals. The chart below demonstrates this analysis. In the first column are the zipcodes of the WAH TP PSA; in the second column are the MSGA discharges to any Maryland hospital in FY 2008; the third and fourth columns shows WAH's and the other Maryland

hospital's market share in FY 2008; and the fifth and sixth column show the hypothetical market share for WAH and the other Maryland hospital's had WAH been operating at the WO campus during FY 2008. The selection of WAH's WO market share is based on assumptions of proximity of the WO location to the selected zipcode areas. (See **Attachment 13**) These assumptions should be considered highly speculative:

The resulting changes in MSGA discharges indicate that some Maryland hospitals would gain MSGA utilization and some would lose utilization as a result of the hypothetical changes in market share between the TP and WO locations:

MSGA

Hospital	TP Share	WO Share	(Loss/Gain)	% Change
WAH	7,909	8,114	205	2.59%
HX	8,524	8,252	-272	-3.19%
DCH	3,337	3,551	214	6.41%
MGH	3,185	2,949	-236	-7.41%
SH	1,747	1,712	-35	-2.00%
PGHC	1,213	1,387	174	14.34%
LRH	1,099	983	-116	-10.56%
Other Md.	2,895	2,961	66	2.28%
TOTAL	29,909	29,909	0	0.00%

A similar analysis was performed for Obstetrics and Psychiatric discharges.

The resulting changes in MSGA discharges indicate that some Maryland hospitals would gain OB and Psychiatric utilization and some would lose utilization as a result of the hypothetical changes in market share between TP and WO:

OBSTETRICS

Hospital	TP Share	WO Share	(Loss/Gain)	%Change
WAH	1,808	2,135	327	18.09%
HX	3,953	3,693	-260	-6.58%
DCH	33	35	2	6.06%
MGH	176	175	-1	-0.57%
SH	4	3	-1	-25.00%
PGHC	777	751	-26	-3.35%
LRH	196	180	-16	-8.16%
Other Md.	665	640	-25	-3.76%
TOTAL	7,612	7,612	0	0.00%

PSYCHIATRIC

Hospital	TP Share	WO Share	(Loss/Gain)	%
WAH	1,059	1,071	12	1.13%
HX	37	39	2	5.41%
DCH	16	17	1	6.25%
MGH	587	520	-67	-11.41%
SH	230	238	8	3.48%
PGHC	293	322	29	9.90%

LRH	253	256	3	1.19%
Other Md.	216	228	12	5.56%
TOTAL	2,691	2,691	0	0.00%

The same model was run to include new zipcode areas that change the PSA between the TP location and the WO locations. The estimate of how the PSA of WAH would change was provided in the response to Completeness Question #32, in which we speculated that two MSGA zipcode areas would leave the PSA and two new zipcode areas would join the PSA. (See **Attachment 14)**

The results for FY 2008 are shown below:

MSGA

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	7,677	8,604	927	12.08%
HX	8,517	7,987	-530	-6.22%
DCH	1,913	2,078	165	8.63%
MGH	3,598	3,220	-378	-10.51%
SH	1,777	1,691	-86	-4.84%
PGHC	823	966	143	17.38%
LRH	1,147	984	-163	-14.21%
Other Md.	2,808	2,730	-78	-2.78%
TOTAL	28,260	28,260	0	0.00%

OBSTETRICS

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,711	2,380	669	39.10%
HX	3,857	3,448	-409	-10.60%
DCH	25	26	1	4.00%
MGH	184	179	-5	-2.72%
SH	3	2	-1	-33.33%
PGHC	731	682	-49	-6.70%
LRH	291	224	-67	-23.02%
Other Md.	1,040	901	-139	-13.37%
TOTAL	7,842	7,842	0	0.00%

PSYCHIATRIC

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,034	1,054	20	1.93%
HX	36	38	2	5.56%
DCH	16	16	0	0.00%
MGH	584	516	-68	-11.64%
SH	224	230	6	2.68%
PGHC	291	319	28	9.62%
LRH	253	256	3	1.19%
Other Md.	210	219	9	4.29%
TOTAL	2,648	2,648	0	0.00%

Finally, to complete the analysis of impact, we assumed that the number of discharges would grow between FY 2008 and FY 2009. These are shown below for each service and for each service area:

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA (2% annual growth rate)

MSGA TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	7,909	26.4%	8,564	24.1%	7.65%
HX	8,524	28.5%	10,266	28.8%	16.97%
DCH	3,337	11.2%	4,093	11.5%	18.46%
MGH	3,185	10.6%	3,912	11.0%	18.58%
SH	1,747	5.8%	2,200	6.2%	20.60%
PGHC	1,213	4.1%	1,565	4.4%	22.48%
LRH	1,099	3.7%	1,429	4.0%	23.09%
Other Md.	2,895	9.7%	3,567	10.0%	18.83%
TOTAL	29,909	100.0%	35,595	100.0%	15.97%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA (1% annual growth rate)

OB TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	1,808	23.8%	1,958	23.6%	7.66%
HX	3,953	51.9%	4,323	52.2%	8.56%
DCH	33	0.4%	36	0.4%	8.33%
MGH	176	2.3%	191	2.3%	7.85%
SH	4	0.1%	4	0.0%	0.00%
PGHC	777	10.2%	841	10.2%	7.61%
LRH	196	2.6%	212	2.6%	7.55%
Other Md.	665	8.7%	715	8.6%	6.99%
TOTAL	7,612	100.0%	8,280	100.0%	8.07%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA (1% annual growth rate)

PSCH Hospital	TP PSA FY 2008	Market Share	FY 2016	Market Share	% change
WAH	1,059	39.4%	1,135	39.2%	6.70%
HX	37	1.4%	39	1.3%	5.13%
DCH	16	0.6%	17	0.6%	5.88%
MGH	587	21.8%	629	21.7%	6.68%
SH	230	8.5%	249	8.6%	7.63%
PGHC	293	10.9%	317	11.0%	7.57%
LRH	253	9.4%	274	9.5%	7.66%
Other Md.	216	8.0%	234	8.1%	7.69%
TOTAL	2,691	100.0%	2,894	100.0%	7.01%

We then made some market share assumptions based on the location of WAH. These are shown below. This chart shows the forecast for the hypothetical WO PSA for MSGA discharges in FY 2016 assuming that WAH remained in TP, and did not relocate:

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

MSGA Hospital	WO PSA FY 2008	Market Share	FY 2016	Market Share
WAH	7,677	27.2%	8,264	25.2%
HX	8,517	30.1%	9,962	30.4%
DCH	1,913	6.8%	2,266	6.9%
MGH	3,598	12.7%	4,266	13.0%
SH	1,777	6.3%	2,143	6.5%
PGHC	823	2.9%	1,008	3.1%
LRH	1,147	4.1%	1,412	4.3%
Other Md.	2,808	9.9%	3,337	10.2%
TOTAL	28,260	100.0%	32,774	100.0%

The second chart show the forecast for the hypothetical WO PSA for MSGA discharges in FY 2016 assuming that WAH relocated from TP to WO, and market shares changed as a result of the relocation:

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

MSGA WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	8,604	30.4%	9,262	28.3%
HX	7,987	28.3%	9,342	28.5%
DCH	2,078	7.4%	2,462	7.5%
MGH	3,220	11.4%	3,818	11.7%
SH	1,691	6.0%	2,039	6.2%
PGHC	966	3.4%	1,183	3.6%
LRH	984	3.5%	1,211	3.7%
Other Md.	2,730	9.7%	3,244	9.9%
TOTAL	28,260	100.0%	32,774	100.0%

The same type of analysis was performed for both Obstetrics and Psychiatric services:

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

OB WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,711	21.8%	1,842	21.7%
HX	3,857	49.2%	4,187	49.4%
DCH	25	0.3%	27	0.3%
MGH	184	2.3%	198	2.3%
SH	3	0.0%	3	0.0%
PGHC	731	9.3%	787	9.3%
LRH	291	3.7%	313	3.7%
Other Md.	1,040	13.3%	1,113	13.1%
TOTAL	7,842	100.0%	8,475	100.0%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

OB WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	2,380	30.3%	2,562	30.2%
HX	3,447	44.0%	3,742	44.2%
DCH	26	0.3%	28	0.3%
MGH	179	2.3%	193	2.3%
SH	2	0.0%	2	0.0%
PGHC	682	8.7%	734	8.7%
LRH	224	2.9%	241	2.8%
Other Md.	901	11.5%	964	11.4%
TOTAL	7,841	100.0%	8,474	100.0%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

PSYCH WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,034	39.0%	1,103	38.9%
HX	36	1.4%	38	1.3%
DCH	16	0.6%	17	0.6%
MGH	584	22.1%	623	22.0%
SH	224	8.5%	241	8.5%
PGHC	291	11.0%	313	11.0%
LRH	253	9.6%	272	9.6%
Other Md.	210	7.9%	226	8.0%
TOTAL	2,648	100.0%	2,834	100.0%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

PSYCH WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,054	39.8%	1,125	39.7%
HX	38	1.4%	40	1.4%
DCH	16	0.6%	17	0.6%
MGH	516	19.5%	550	19.4%
SH	230	8.7%	248	8.7%
PGHC	319	12.0%	343	12.1%
LRH	256	9.7%	276	9.7%
Other Md.	219	8.3%	236	8.3%
TOTAL	2,648	100.0%	2,834	100.0%

With respect to the impact on revenues, we calculated the changes in revenues by hospital by service for each of the two PSA assumptions. It should be noted that the average revenue per case was not adjusted for case-mix. These are shown below.

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

MSGA Hospital	TP PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	7,909	8,114	205	2.59%	$13,283	$2,723,015
HX	8,524	8,252	-272	-3.19%	$12,161	-$3,307,792
DCH	3,337	3,551	214	6.41%	$9,281	$1,986,134
MGH	3,185	2,949	-236	-7.41%	$10,461	-$2,468,796
SH	1,747	1,712	-35	-2.00%	$11,611	-$406,385
PGHC	1,213	1,387	174	14.34%	$14,012	$2,438,088
LRH	1,099	983	-116	-10.56%	$9,204	-$1,067,664
Other Md.	2,895	2,961	66	2.28%	$13,000	$858,000
TOTAL	29,909	29,909	0	0.00%		$754,600

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

MSGA Hospital	WO PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	7,677	8,604	927	12.08%	$13,283	$12,313,341
HX	8,517	7,987	-530	-6.22%	$12,161	-$6,445,330
DCH	1,913	2,078	165	8.63%	$9,281	$1,531,365
MGH	3,598	3,220	-378	-10.51%	$10,461	-$3,954,258
SH	1,777	1,691	-86	-4.84%	$11,611	-$998,546
PGHC	823	966	143	17.38%	$14,012	$2,003,716
LRH	1,147	984	-163	-14.21%	$9,204	-$1,500,252
Other Md.	2,808	2730	-78	-2.78%	$13,000	-$1,014,000
TOTAL	28,260	28,260	0	0.00%		$1,936,036

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

OB Hospital	TP PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	1,808	2,135	327	18.09%	$4,484	$1,466,268
HX	3,953	3,693	-260	-6.58%	$4,700	-$1,222,000
DCH	33	35	2	6.06%	$4,351	$8,702
MGH	176	175	-1	-0.57%	$3,701	-$3,701
SH	4	3	-1	-25.00%	$5,124	-$5,124
PGHC	777	751	-26	-3.35%	$5,259	-$136,734
LRH	196	180	-16	-8.16%	$4,478	-$71,648
Other Md.	665	640	-25	-3.76%	$5,307	-$132,675
TOTAL	7,612	7,612	0	0.00%		-$96,912

Forecasted Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH TP PSA

OB Hospital	WO PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	1,711	2,380	669	39.10%	$4,484	$2,999,796
HX	3,857	3,448	-409	-10.60%	$4,700	-$1,922,300
DCH	25	26	1	4.00%	$4,351	$4,351
MGH	184	179	-5	-2.72%	$3,701	-$18,505
SH	3	2	-1	-33.33%	$5,124	-$5,124
PGHC	731	682	-49	-6.70%	$5,259	-$257,691
LRH	291	224	-67	-23.02%	$4,478	-$300,026
Other Md.	1,040	901	-139	-13.37%	$5,307	-$737,673
TOTAL	7,842	7,842	0	0.00%		-$237,172

Forecasted Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH TP PSA

PSYCH Hospital	TP PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	1,059	1,071	12	1.13%	$5,936	$71,232
HX	37	39	2	5.41%	$9,951	$19,902
DCH	16	17	1	6.25%	$7,874	$7,874
MGH	587	520	-67	-11.41%	$6,694	-$448,498
SH	230	238	8	3.48%	$6,790	$54,320
PGHC	293	322	29	9.90%	$5,721	$165,909
LRH	253	256	3	1.19%	$10,121	$30,363
Other Md.	216	228	12	5.56%	$8,051	$96,612
TOTAL	2,691	2,691	0	0.00%		-$2,286

Forecasted Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH TP PSA

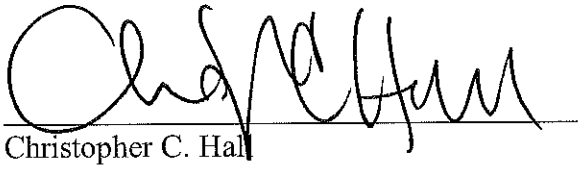
PSYCH Hospital	TP PSA TP Share	WO Share	(Loss/Gain)	% change	FY 2008 Average Charge	Revenue Impact
WAH	1,034	1,054	20	1.93%	$5,936	$118,720
HX	36	38	2	5.56%	$9,951	$19,902
DCH	16	16	0	0.00%	$7,874	$0
MGH	584	516	-68	-11.64%	$6,694	-$455,192
SH	224	230	6	2.68%	$6,790	$40,740
PGHC	291	319	28	9.62%	$5,721	$160,188
LRH	253	256	3	1.19%	$10,121	$30,363
Other Md.	210	219	9	4.29%	$8,051	$72,459
TOTAL	2,648	2,648	0	0.00%		-$12,820

ATTACHMENTS

1. Current and proposed bed capacity by physical location
2. Revised Chart 1
3. Revised Project Budget
4. Special Exception and Site plan documents
5. Options decision grid
6. Site selection decision grid
7. Minutes - Montgomery County Healthcare Collaborative on Emergency Preparedness
8. OR historical data
9. Revised drawings
10. Psych written discharge planning policies
11. Audited financial statements
12. Cash flow projections
13. Attachment 1 of impact analysis
14. Attachment 2 of impact analysis
15. A detailed list of the extraordinary cost items excluded from the MVS analysis with explanations

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

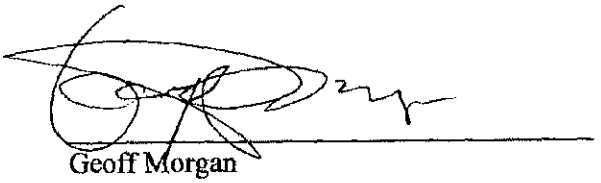


Christopher C. Hall
Sr. Director Strategic Planning

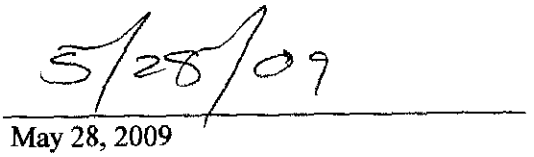
5.29.09
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.



Geoff Morgan
Vice President, Expanded Access
Washington Adventist Hospital



May 28, 2009

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

Romel Punsalan
Exec. Director of Facilities
Washington Adventist Hospital
[Name and Title]

5/27/2009
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

Thomas E. Chan V.P., Financial Services — May 27, 2009

[Name and Title] Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

David S Cohen

May 29, 2009

David S Cohen

Date

Cohen, Rutherford + Knight

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

RJ Coughlan

Richard J. Coughlan

5/29/09

Date

Attachment 1

Current and proposed bed capacity by physical location

Washington Adventist Hospital 5/29/2009

Location	Existing Physical Capacity					Location	After Project Completion					NOTES
		Room Count			Bed Count			Room Count			Bed Count	
(Floor/Wing)	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity	(Floor/Wing)	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity	
TCU LL 1	MSGA (cardiovascular)	8	0	8	8	2nd North	MCGA (critical care)	32	0	32	32	
1500 ICU 1st	MSGA (critical care cardiovascular)	16	0	16	16	3 South	OB (obstretrics post partum)	30	0	30	30	
*2100 2nd	Psych (Behavorial Health)	25	14	11	40	3 South	MSGA (medical surgical)	6	0	6	6	
2200 2nd	MSGA (orthopedic)	30	9	20	38	4 North	Psych (behavorial health)	37	3	34	40	
2500 2nd	MSGA (cardiovascular)	17	14	3	31	4 South	MSGA (medical surgical)	36	0	36	36	
3100 3rd	OB (obstetrics post partum)	20	10	10	30	5 North	MSGA (intermediate care medical surgical)	36	0	36	36	
3200 3rd	MSGA (oncology)	22	7	15	29	5 South	MSGA (oncology medical surgical)	36	0	36	36	
*4100 4th	MSGA (intermediate care)	18	15	3	34	6 North	MSGA (cardiovascular	36	0	36	36	
*4200 4th	MSGA (medical surgical)	26	7	20	37	6 South	MSGA (orthopedic)	36	0	36	36	
4300 ICU 4th	MSGA (critical care medical surgical)	10	0	10	10							
*5100 5th	MSGA (cardiovascular)	15	14	1	30							
5300 5th	MSGA (coronary care)	7	1	6	8							
Total		214	91	123	311	**Total**		285	3	282	288	

Note: * indicates floors that have semi private rooms with three beds

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall that can be used to accommodate more than one patient (e.g., for psychiatric patients), report the physical capacity of such rooms as semi-private, and report the bed capacity as applicable.

Attachment 2

Revised Chart 1

Hospital		
Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$ 6,700,000	
Normal Site Preparation*	$ 2,314,288	
Demolition	$ 49,325	
Storm Drains	$ 1,034,475	
Rough Grading	$ 2,563,835	
Hillside Foundation	$ 737,623	
Terracing		
Pilings		
Offsite Costs	$	
Roads	$ 2,903,282	
Utilities	$ 679,121	
Jurisdictional Hook-up Fees	$ 500,000	
Signs	$ 2,000,000	
Landscaping	$ 688,103	

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

Parking Garages		
Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$ 1,450,000	
Normal Site Preparation*	$ 500,853	
Demolition	$ 10,675	
Storm Drains	$ 223,879	
Rough Grading	$ 554,860	
Hillside Foundation	$ 159,635	
Terracing		
Pilings		
Offsite Costs	$	
Roads	$ 628,146	
Utilities	$	
Jurisdictional Hook-up Fees	$	
Signs	$ 200,000	
Landscaping	$	

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

Attachment 3

Revised Project Budget

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. ***Use of Funds (Hospital)***

1. *Capital Costs:*

a.	*New Construction*		
(1)	*Building*		*$163,583,000*
(2)	*Fixed Equipment (not included in construction)*		*$ 25,592,000*
(3)	*Land Purchase*		*$ -*
(4)	*Site Preparation*		*$ 6,700,000*
(5)	*Architect/Engineering Fees*		*$ 15,300,000*
(6)	*Permits, (Building, Utilities, Etc)*		*$ 526,000*
SUBTOTAL		*$*	*211,701,000*
b.	*Renovations*		
(1)	*Building*	*$*	_____
(2)	*Fixed Equipment (not included in construction)*		_____
(3)	*Architect/Engineering Fees*		_____
(4)	*Permits, (Building, Utilities, Etc.)*		_____
SUBTOTAL		*$*	_____
c.	*Other Capital Costs*		
(1)	*Major Movable Equipment*		*27,024,000*
(2)	*Minor Movable Equipment*		*7,625,000*
(3)	*Contingencies*		*25,855,000*
(4)	*Other (IS, COMM, Security, Furniture, Signage, Re-location Expense, Etc.)*		*27,000,000*
(5)	*Equip Transferred from Old Hospital, Net*	*$*	*15,380,000*
SUBTOTAL		*$*	*102,884,000*
TOTAL CURRENT CAPITAL COSTS *(a - c)*		*$*	*314,585,000*
d.	*Non Current Capital Cost*		
(1)	*Interest (Gross)*	*$*	*60,849,000*
(2)	*Inflation Allowance (2.5% per year for 3 yrs, Apr 09 – Apr 2012, mid-point of Construction)*	*$*	*23,320,000*
TOTAL PROPOSED CAPITAL COSTS(a-d)		*$*	*398,754,000*

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds [2 parking structures]

1. Capital Costs:

a.	*New Construction*	
(1)	*Building*	*$ 35,200,000*
(2)	*Fixed Equipment (not included in construction)*	*$ -*
(3)	*Land Purchase*	*$ -*
(4)	*Site Preparation*	*$ 1,450,000*
(5)	*Architect/Engineering Fees*	*$ 2,200,000*
(6)	*Permits, (Building, Utilities, Etc)*	*$ -*
SUBTOTAL		*$ 38,850,000*
b.	*Renovations*	
(1)	*Building*	*$* _____
(2)	*Fixed Equipment (not included in construction)*	_____
(3)	*Architect/Engineering Fees*	_____
(4)	*Permits, (Building, Utilities, Etc.)*	_____
SUBTOTAL		*$* _____
c.	*Other Capital Costs*	
(1)	*Major Movable Equipment*	*-*
(2)	*Minor Movable Equipment*	*-*
(3)	*Contingencies*	*$ 1,945,000*
(4)	*Other (IS, COMM, Security, Furniture, Signage, Re-location Expense, Etc.)*	*-*
SUBTOTAL		*$ 1,945,000*
TOTAL CURRENT CAPITAL COSTS *(a - c)*		*$ 40,795,000*
d.	*Non Current Capital Cost*	
(1)	*Interest (Gross)*	*$ 7,919,000*
(2)	*Inflation Allowance(2.5% per year for 3 yrs, Apr 09 – Apr 2012, mid-point of Construction)*	*$ 3,180,000*
TOTAL PROPOSED CAPITAL COSTS (a-d)		*$ 51,894,000*

Attachment 4

Special Exception and Site plan documents

Prior to approval of the roadway construction drawings, Applicant shall provide documentation acceptable to the Executive Branch review agencies that satisfactorily demonstrates the proposed intersection improvements will be adequate to accommodate the turning movements of WB-50 trucks and emergency response vehicles. The aforementioned intersection improvements may be expanded to accommodate these turning movement requirements.

If required as a result of Executive Branch approval of the roadway construction (and/or related Signs and Markings Plan), Applicant shall re-stripe Plum Orchard Road. Applicant shall also construct pedestrian refuge islands if approved under that review.

Applicant will be required to relocate any existing underground utilities, at its sole expense, if those utilities will be located within the proposed widened roadway pavement or in conflict with the relocated enclosed storm drain system.

d. Provide hospital-oriented employee shuttle(s) for main shift employees to and from the Metrorail system for a total of 10 years from the date the hospital opens to the public or until an earlier date if the Planning Board determines that area public transit service adequately meets the needs of these employees. The details of the shuttle operation (routes, locations, headways, etc.) must be determined at the time of Site Plan. Logistics related to the operation of the employee shuttle(s) must be in place prior to release of the first occupancy permit for the hospital and/or any other on-site building. The employee shuttle service must start operation at least a week prior to formal opening of the proposed hospital.

e. The applicant shall submit a Memorandum of Understanding (MOU) to implement a Transportation Management Program (TMP) for the proposed hospital at the time of Site Plan. The applicant, the Maryland-National Capital Park and Planning Commission and the Department of Transportation shall each be signatory parties on the MOU for the TMP for this project. The MOU and the TMP must be finalized and entered into prior to the release of building permits for the proposed hospital and/or any other on-site building.

The TMP must designate a Transportation Coordinator at the hospital. The TMP must also include a periodic reporting mechanism such as a semi-annual performance review of the program by DOT or the Planning Board staff, as well as periodic reports to a Community Liaison Committee that may include members of the local community, area businesses and institutions, and Citizen Advisory Committees. In addition, the program must consider transit subsidies to employees, establishment of creative transportation accessibility options for employees, patients and visitors,

Attachment No. 2 – email from DOT) for the following intersections:

a. Plum Orchard Road/Broad Birch Drive,
b. Plum Orchard Road/South Main Entrance to the Hospital (Private Street A), and
c. Broad Birch Drive/Tech Road.

A formal confirmation letter on the above is expected from DOT in the near future.

2. **Special Exception Condition No. 5d – "Provide hospital-oriented employee shuttle(s) for main shift employees to and from the Metrorail system for a total of 10 years from the date the hospital opens to the public or until an earlier date if the Planning Board determines that area transit service adequately meets the needs of these employees. The details of the shuttle operation (routes, locations, headway, etc.) must be determined at the time of Site Plan."**

   The Applicant is working with Planning Department staff, DOT staff, and the People's Counsel, and has incorporated details of the employee shuttle operation into a broad Transportation Management Agreement (TMA) (see Attachment No. 3) to be executed by the Applicant, the Planning Board and DOT. Staff notes that deviation from Special Exception Condition No. 5d (regarding providing employee shuttle to and from the Metrorail system) was deliberate and based upon Hospital's survey of its current employees and their anticipated commuting patterns to and from the new Hospital. During TMA discussions, staff and the People's Counsel agreed on a shuttle route between the existing Takoma Park campus and the new West*Farm hospital campus in lieu of a shuttle between the new Hospital and the Metrorail system as was anticipated during the special exception. Staff believes that the TMA provides adequate flexibility in making modifications to the shuttle route to include Metrorail stops if employee commuting patterns warrant a change in the future. Additionally, staff note that WMATA and RideOn will be providing service along Plum Orchard Road, Broad Birch Drive, and Cherry Hill Road, and could also provide the necessary connections between the Hospital and area Metrorail stations.

3. **Special Exception Condition No. 5e – "The applicant shall submit a Memorandum of Understanding (MOU) to implement a Transportation Management Program (TMP) for the proposed hospital at the time of Site Plan. The applicant, the Maryland-National Capital Park and Planning Commission and the Department of Transportation shall each be signatory parties on the MOU for the TMP for this project. The MOU and TMP must be finalized and entered into prior to the release of building permits for the proposed hospital and/or any other on-site building."**

   See Attachment No. 3. The Applicant is working with Planning Department staff, DOT staff, and the People's Counsel on details of a broad Transportation Management Agreement (TMA) to be executed by the Applicant, the Planning Board, and DOT.

4. **Special Exception Condition No. 5f – "The applicant must submit a vehicular/non-vehicular circulation plan for the campus at the time of Site Plan for review by the**

EXHIBIT C

WASHINGTON ADVENTIST HOSPITAL
SHUTTLE PROGRAM

December 2008

The Washington Adventist Hospital ("WAH") Employee Shuttle Program will consist of two buses operating between WAH at Plum Orchard Drive and its Takoma Park campus. Buses will leave each site approximately every half an hour during the AM and PM peak hours. During the AM peak, the first bus will leave Takoma Park at 6:00 am and the last bus will leave WAH at 9:00 am. During the PM peak, the first bus will leave Takoma Park at 2:30 pm and the last bus will leave WAH at 5:30 pm. Initially, the route that buses will travel is via Carroll Avenue, Piney Branch Road, New Hampshire Avenue, Powder Mill Road, Cherry Hill Road, Broadbirch Drive and Plum Orchard Drive.

Attachment 5

Options decision grid

Washington Adventist Hospital
Campus Plan
Decision Options

		Today	Required	Option A	Option B	Option C	Option D
1	**Future State**		Required to keep hospital operating	Move key service lines to another facility. Reduce hospital capacity to 150 to 200 beds and move beds to Clarksburg and/or Shady Grove. No MOB or parking structure constructed. Convert select hospital space to MOB space. Hospital transforms to a basic community hospital	Continue operating as a full-service hospital. Construct new MOB and parking structure	Continue Operating as a full-service hospital with significant investment	Build new 250 to 300 bed replacement hospital
2			In the next 10 to 15 years, the 1950s building must be raised or totally refurbished. This tower includes 100 beds. The costs to refurbish or replace - in todays dollars - will range from $80M to $90M. In addition, analysis shows that the facility will require $3M to 5M million of additional capital per year over several years in facility improvement projects not addressed in option C. Lastly, a replacement of this building would be highly disruptive to hospital operations and would significantly reduce available bed capacity throughout the construction period				
3	**Level of Investment (not including medical equipment)**		$42M to $55M	$55 to $69M	$90M to $104M	$139M to $187M	$304M
4	**Subtotal Level of Investment (Row 2 +Row3)**		$134M to $165M	$147M to $179M	$182M to $214M	$231M to $297M	$304M
5	**What does Option Accomplish or fix?**		Address deferred maintenance: roofs, generators, electrical systems, air handlers, chillers, boilers, basic and renovation of old patient care units. No increase in private bed capacity.	Required + additional investment to convert hospital space to MOB space	Option A + ED expansion, modify hospital entrace, new drive access, modernize hospital, new MOB and parking structure. No increase in private bed capacity.	Option B + Add 4 floors, Reach 75% private rooms, re-program services for greater efficiency, new virtical circulation coridors ($ depends on scope of project)	Secure a more predictable future for WAH ($ estimated at $650K to $900K per bed). All private beds.
6	**Score Criteria**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
	Hospital Score						
	Access to the Campus / Location	1	1	1	1	1	10
	Parking	3	3	4	6	6	10
	Aesthetics	3	3	4	5	7	10
	Patient Flow / Efficiency	3	3	4	6	7	10
	Private Bed Capacity	4	4	7	4	7	10
	Building Utility Systems	2	7	7	7	7	10
	Impact to Current Operations	-	1	1	1	1	10
	Future Inpatient Bed Capacity	3	3	4	5	7	10
	Outpatient Capacity / Accessability	3	3	4	5	7	9
	Site Expansion Potential	1	1	1	1	1	8
	Physician Recruitment Opportunities	2	3	4	6	7	10
	Total Score	**2.3**	**2.9**	**3.7**	**4.3**	**5.3**	**9.7**

Scale: 1 to 10 where 1 is worst and 10 is best

Attachment 6

Site selection decision grid

Washington Adventist Hospital
Site Selection
Decision Grid

	Site #1	Site #2	Site #3	Site #4	Site #5
Location	University Blvd. at Carroll Ave. ~ 1 mile from existing site, Silver Spring MD	College Park, MD	White Oak along New Hampshire Ave, Silver Spring MD	25 acre site off Industrial Blvd and Rout2 29, Silver Spring MD	Plum Orchard, Silver Spring MD
Estimated Distance from Existing Site	1 mile	4 miles	4 miles	6.5 miles	6.5 miles
Control of Property	Not Likely - Privately owned by multiple entities and would require school relocation	No - State owned	No - Federal Government owned	No - Local Government owned	Yes
Scope	Split Campus - partial relocation	Full Relocation	Full Relocation	Full Relocation	Full Relocation
Score Criteria	**Score**	**Score**	**Score**	**Score**	**Score**
Score					
Access to the Campus / Location	3	3	7	10	10
Available Acreage	10	5	5	4	10
Purchase to Own	1	1	1	1	10
Zoning	5	5	5	5	8
Existing Public Transportation	10	7	4	2	5
Feasibility	1	1	1	4	10
Within Existing Primary Service Area	10	5	10	10	10
Within Montgomery County	10	1	10	10	10
Area Compatibility	2	4	7	10	10
Ease of Development	1	5	2	5	10
Natural Setting for Healing Environment	2	2	5	5	8
Access to Science and Technology Organization(s)	3	4	10	10	10
Total Score	**4.8**	**3.6**	**5.6**	**6.3**	**9.3**

Scale: 1 to 10 where 1 is worst and 10 is best

Attachment 7

Minutes - Montgomery County Healthcare Collaborative on Emergency Preparedness

Montgomery County Healthcare Collaborative on Emergency Preparedness

MOCEP

Montgomery County Healthcare Collaborative on Emergency Preparedness

Meeting Minutes
March 6th, 2009
8:00 a.m. – 10:00 a.m.
Montgomery General Hospital
Denit Board Room

COMMITTEE MEMBERS: Sandy Alban, Clark Beil, Rosalie Collins, Dave Cummings, Jennifer DeMatteo, Keith Frederick, Roy Gilmore, Pat Hawes, Walter Hawkins, William Hentosh, Brian Hunt, Roger Hunter, Bill Kelly, Sheri Lewis, Richard Mandel, Cindy Notobartolo, Michael Anne Preas, Kent Schod, Julie Sydlowski, Ulder Tillman, Kathleen Timmons, Kathleen Wood

PRESENT: Bill Kelly, Kent Schod, Richard Mandel, Brian Hunt, Cindy Notobartolo, Kathleen Wood, Michael Ann Preas, William Hentosh, Kathleen Timmons, Walter Hawkins, Robert Lisk, Leroy Gross, Pat Hawes, Keith Frederick

INVITEES: n/a

ITEM	DISCUSSION	ACTION	FOLLOW-UP
CALL TO ORDER:	Kathleen Timmons called the meeting to order		
REVIEW OF MINUTES:	Minutes of the January 6th meeting distributed for review.	Amend minutes to strike Sheri Lewis from the committee.	JL
MMRS project update	The Metro Medical Response Systems steering committee has been meeting biweekly. No timeframe until a contract is awarded. Looking for input from hospitals and healthcare facilities. The Office of Homeland Security will hire one staff member to do the legwork.	Ongoing	CN
Upcoming exercises	C. Notobartolo indicated there may not be a state-wide exercise this year. The Presidential Inauguration can be used as our exercise. CMAX '09 will be in September. Hospitals will have to focus on surge. K. Schod indicated his hospital will be testing evacuation of patients due to surge in April and requested any hospital who may want to participate as the receiving facility to test their surge. Kaiser will be doing a national pandemic flu drill on June 18th. Medstar facilities have a drill in June, no date	Ongoing More discussion at Apr. meeting	CN

ITEM	DISCUSSION	ACTION	FOLLOW-UP
	specified.		
Survey for UASI Gap Analysis	The survey due on March 6th has been extended to close of business on the 9th.	Send completed survey to Pat Hawes	PH
New WAH location	B. Hentosh spoke about the possibility of building a parking garage at the new hospital location that can be converted into a field hospital using a tent system to be used by all county hospitals as a surge facility. Input requested from MOCEP members.	Bill Kelly, Pat Hawes and Kent Schod will offer input on the future project	BH
State-provided ventilator supply update	State needs more time.		KT
MOCEP MOU	All MOCEP members to review the MOCEP MOU.	Send edits to K. Timmons	KT
Region V MOU	Prior to March 19th, MOCEP group to set up conference call to discuss the MOU	Ongoing	KT
Collection of Inaugural expense forms	All forms should be sent to K. Timmons asap for possible reimbursement.		KT
DHMH HPP call summary	K. Schod sent an email to all members with the NCR H&M Technology Task Force project update. Items covered including patient tracking system, microwave communication systems and MD state communications.	Additional updates to be provided	KS
Agenda items not covered due to time constraints	11 - Meeting with Region V Health and Medical Task Force 12 – Statewide anti-viral storage site visits 13 - Statewide patient tracking program being re-initiated	Add to future agenda as necessary	JL
Weekly Radio Call Down Drill	B. Kelly reminded everyone of their radio check.	Add radio call down procedure to the next agenda.	BK
Crime Solvers of Montgomery County	K. Timmons is on the board of Crime Solvers of Montgomery County	Ongoing	KT
MOCEP representation to the MC EOC	Montgomery County EOC has offered a member of MOCEP a chair in the MC EOC.	Discuss on agenda	JL
Stop the Spread	K. Wood indicated the project has been completed. Each facility represented received 2 brochures c/ CDs. Facilities can go on website to order additional CDs		KW
NEXT MEETING DATE	**Next meeting will be April 3rd, 2009, 8-10am at Montgomery General Hospital in the Conference Room B, Ground Level.**	Note location change – due to construction, meetings will be held in Conference Room B until further notice	None

Kathleen Timmons
AHC Corporate Director of Public Safety & Security

Minutes submitted by Walter Hawkins
Director of Security, Washington Adventist Hospital

Attachment 8

OR historical data

Washington Adventist Hospital
OR Cases and Minutes by FY
FY 2004 - 2008

	Inpt Cases	Outpt Cases	Inpt Minutes	Outpt Minutes
2004	3,209	4,125	499,229	249,567
2005	3,247	3,899	510,420	257,065
2006	2,968	3,448	461,898	246,475
2007	2,744	3,259	418,770	228,144
2008	2,663	3,597	401,018	228,002

*Excludes Endo, Cysto & Litho

Attachment 9

Revised drawings

WASHINGTON ADVENTIST HOSPITAL
REPLACEMENT PROJECT

CON APPLICATION

04.10.2009

Washington Adventist Hospital

CONTACT
Godfrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Laiederman Soltesz Associates, Inc., Rockville MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
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McRand & Knight LLP, Bethesda, MD
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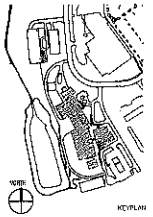

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

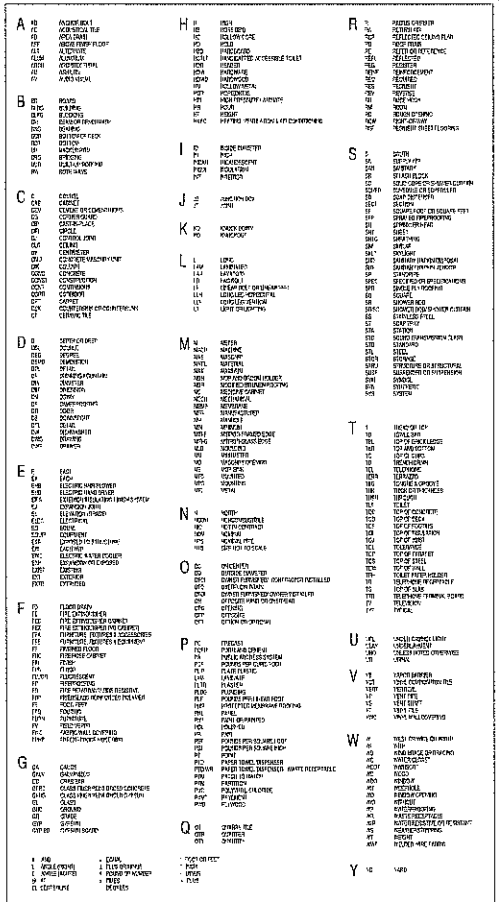
CON APPLICATION

COVER SHEET

Scale:
RTKL Contract No. 20-07011.01
Issue Date: 04.10.2009
Last Revision:

G-000

ABBREVIATIONS & NOTATIONS



INDEX OF SHEETS

SHEET INDEX - CON APPLICATION	
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A-001	ARCHITECTURE INDEX AND GENERAL INFORMATION
A-100	ILLUSTRATIVE SITE PLAN
A-110	CELLAR LEVEL FLOOR PLAN
A-110A	MAIN HOSPITAL CELLAR LEVEL FLOOR PLAN - SOUTH
A-110B	MAIN HOSPITAL CELLAR LEVEL FLOOR PLAN - NORTH
A-111	LEVEL 1 FLOOR PLAN
A-111A	MAIN HOSPITAL LEVEL 1 FLOOR PLAN - SOUTH
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A-112	LEVEL 2 FLOOR PLAN
A-112A	MAIN HOSPITAL LEVEL 2 FLOOR PLAN - SOUTH
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A-113	LEVEL 3 FLOOR PLAN
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A-114	LEVEL 4 FLOOR PLAN
A-114A	MAIN HOSPITAL LEVEL 4 FLOOR PLAN - SOUTH
A-114B	MAIN HOSPITAL LEVEL 4 FLOOR PLAN - NORTH
A-115	LEVEL 5 FLOOR PLAN
A-115A	MAIN HOSPITAL LEVEL 5 FLOOR PLAN - SOUTH
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A-135	PENTHOUSE LEVEL FLOOR PLAN
A-135A	PENTHOUSE - SOUTH FLOOR PLAN
A-135B	PENTHOUSE - NORTH FLOOR PLAN
A-150	ROOF FLOOR PLAN
A-200	MAIN HOSPITAL EAST AND WEST ELEVATIONS
A-201	MAIN HOSPITAL NORTH AND SOUTH ELEVATIONS

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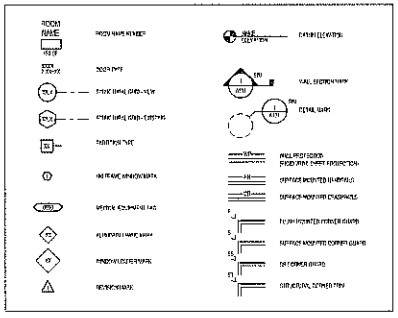

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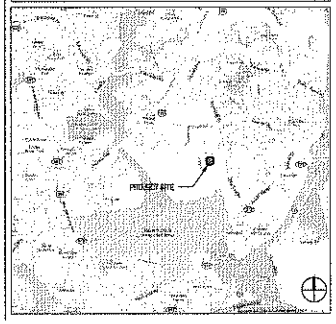

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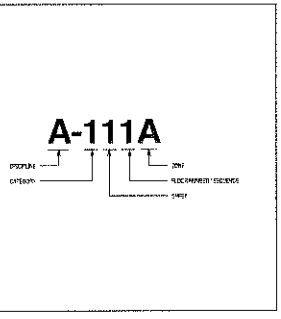

GENERAL NOTES

ISSUE DATES

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5658

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lakedmmon Sallaiz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Copley & Associates, Rockville, MD
Pennoni Planning & Zoning, Inc., Rockville, MD
The Traffic Group, Inc., Baltimore, MD
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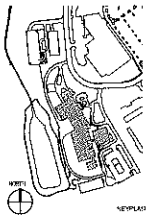

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Washington Adventist Hospital Replacement Project

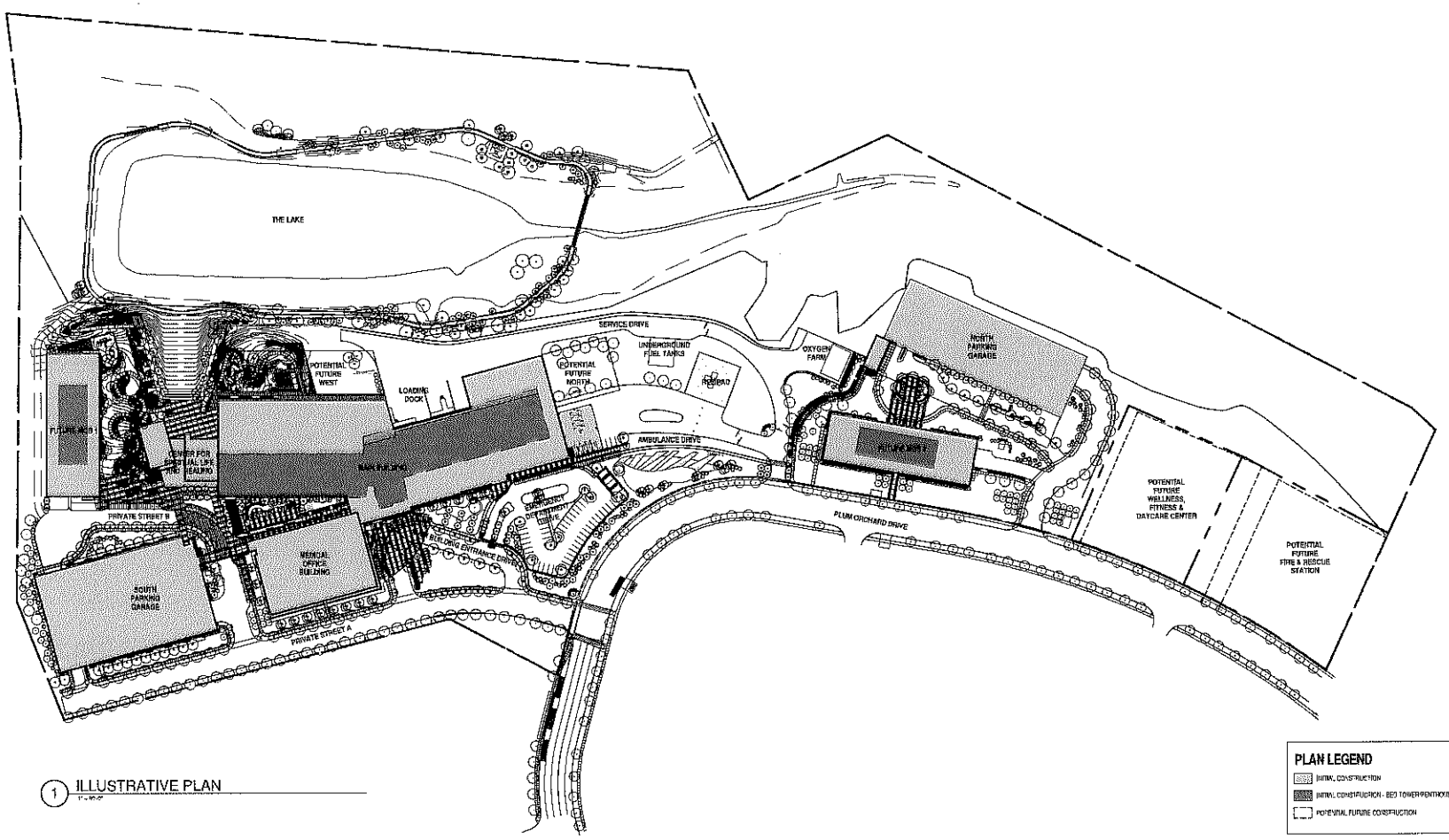
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

ARCHITECTURE
INDEX AND GENERAL INFORMATION

Scale:	As Indicated
RTKL Contract No.	20-07011.01
Issue Date:	04.10.2009
Last Revision:	

A-001



1 ILLUSTRATIVE PLAN
1" = 80'-0"

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lokedomion Sollese Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lewis Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pentes Planning & Zoning, Inc., Rockville, MD
The Traffic Group, Inc., Baltimore, MD
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CON APPLICATION

ILLUSTRATIVE SITE PLAN

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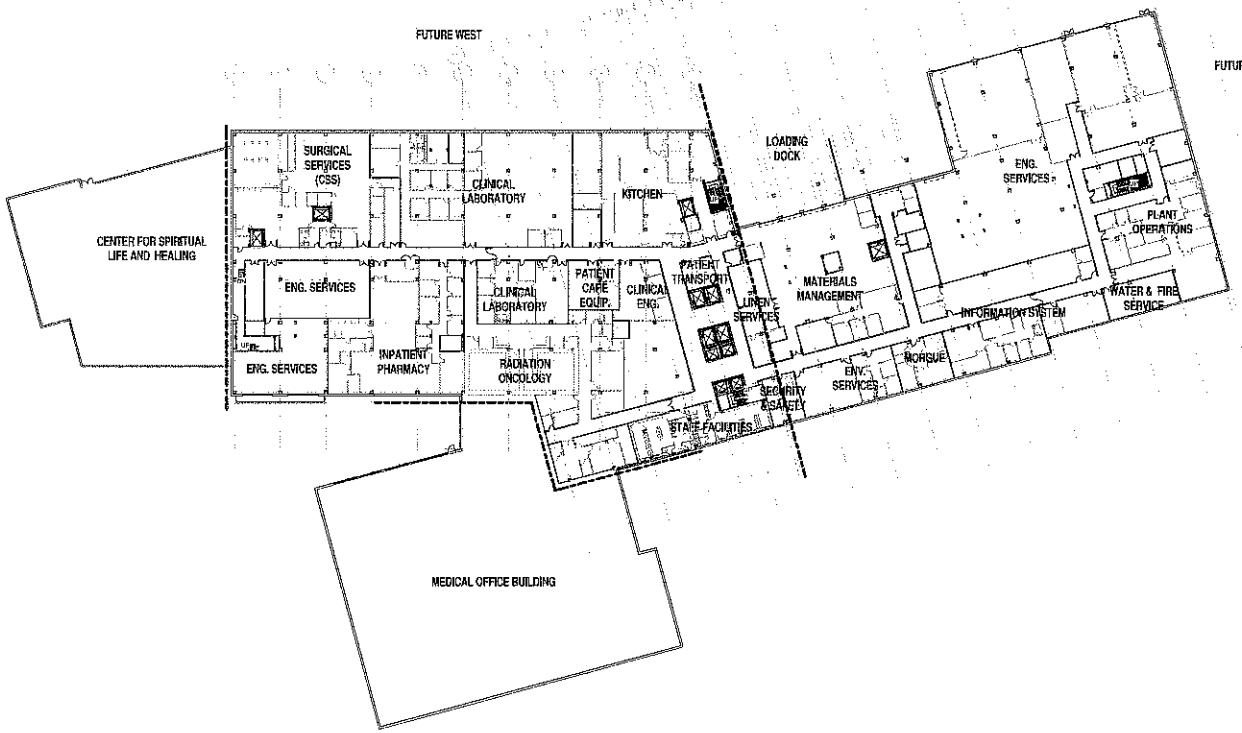

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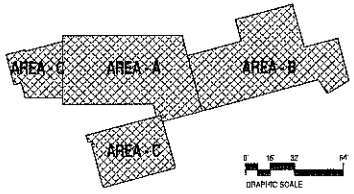

GRAPHIC SCALE

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc., Washington, DC
Lenderman Sollenz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pentad Planning & Zoning, Inc., Rockville, MD
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CELLAR LEVEL FLOOR PLAN

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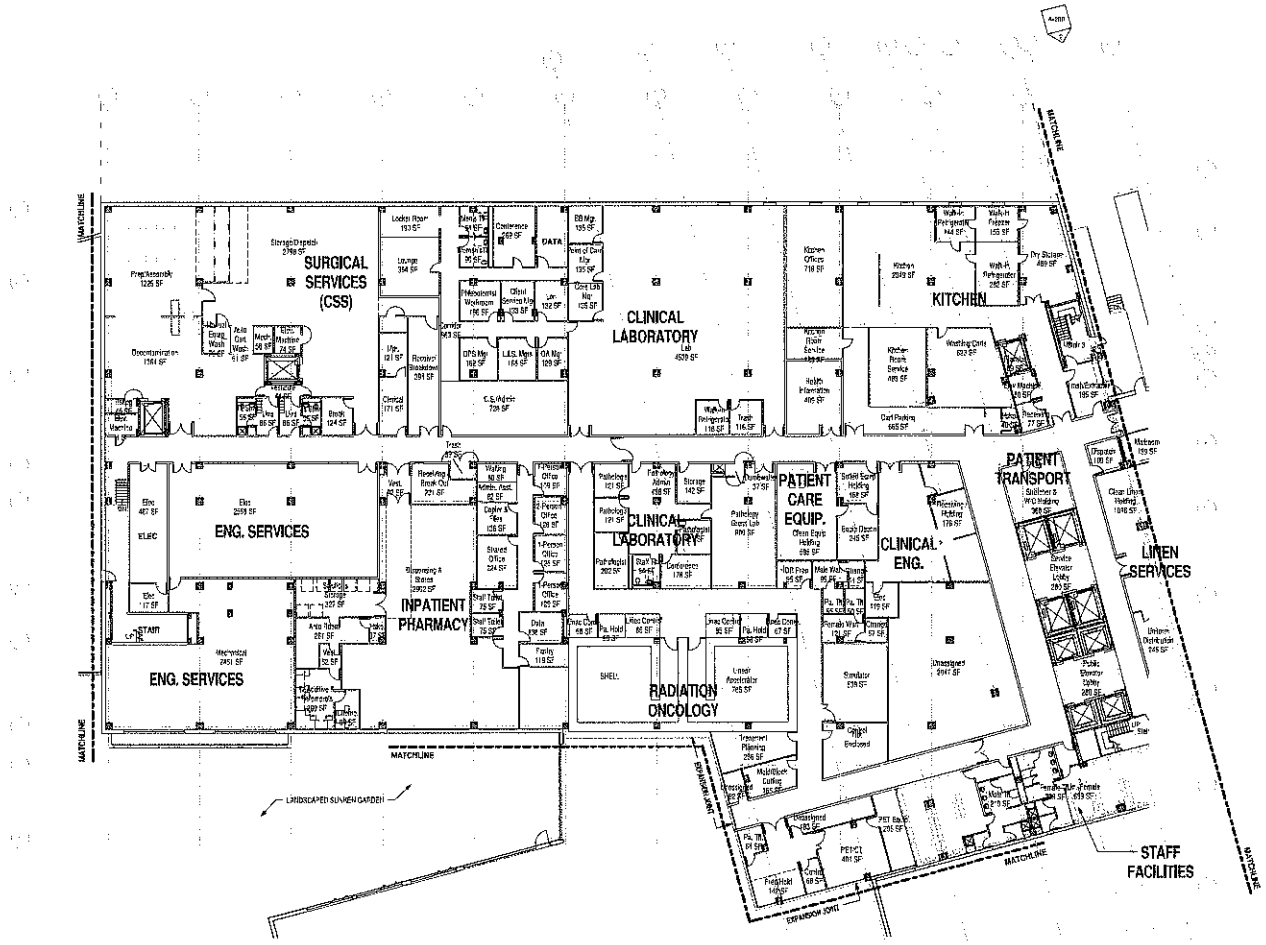
A-110



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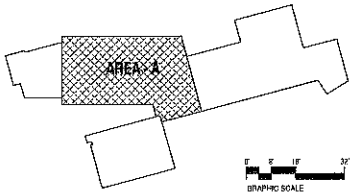

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lowdermilk Salitsky Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
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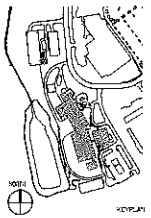

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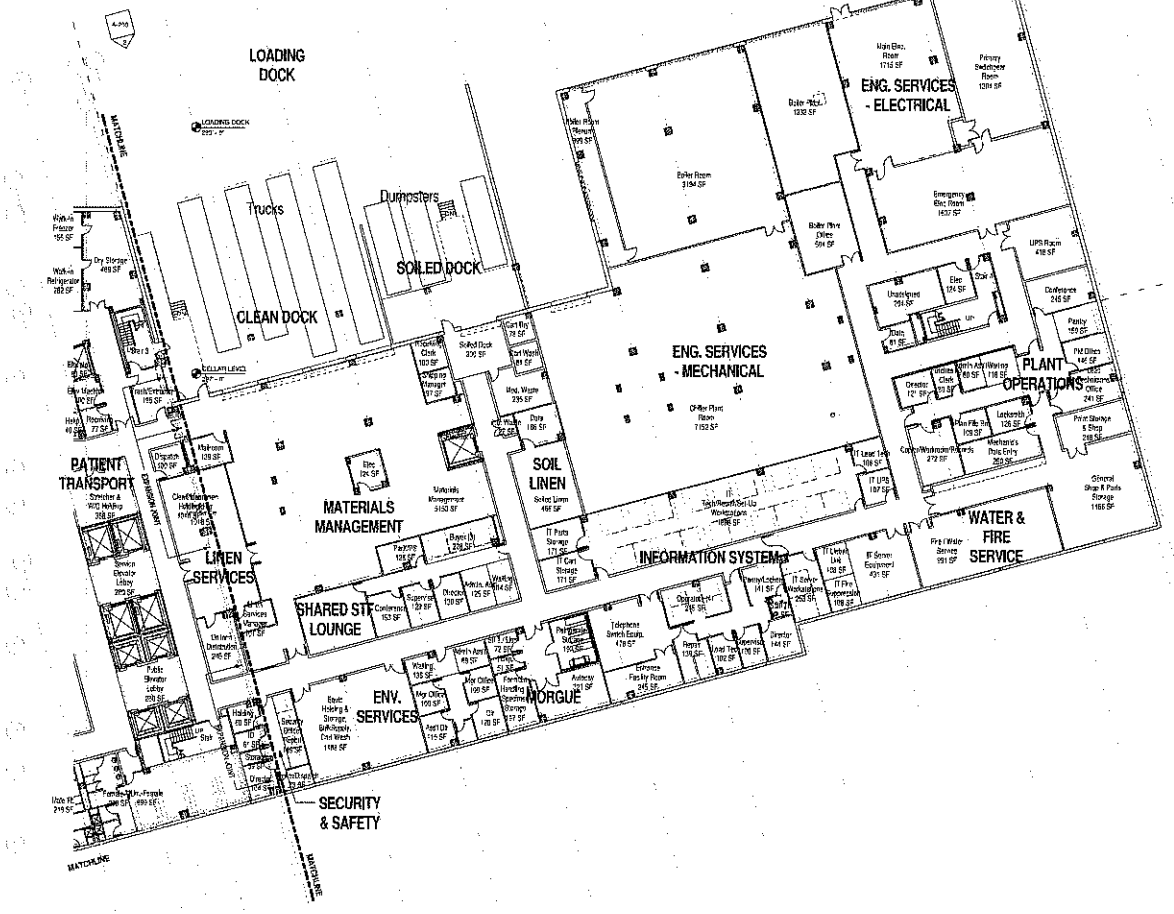

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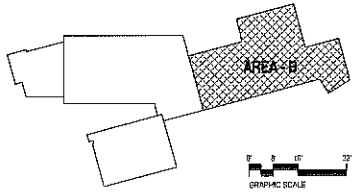

Washington Adventist Hospital

CONTACT
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5468

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lolederman Soltesz Associates, Inc.
Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Loech Walton Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pentex Planning & Zoning, Inc., Rockville, MD
The Traffic Group, Inc., Baltimore, MD
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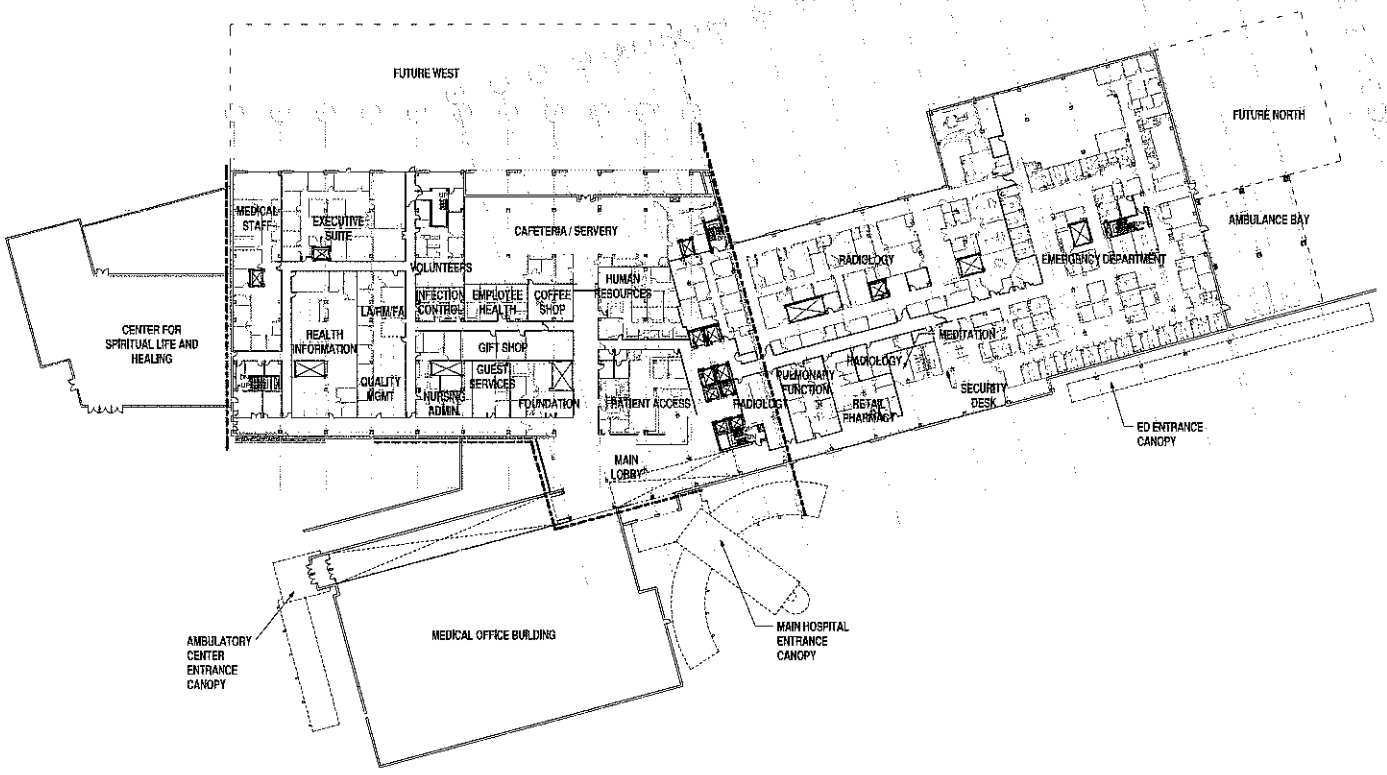
A-110B



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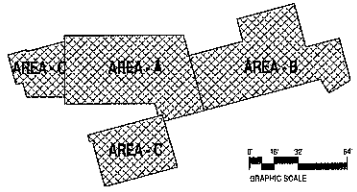

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Loiederman Soltesz Associates, Inc., Rockville, MD
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LEVEL 1 FLOOR PLAN

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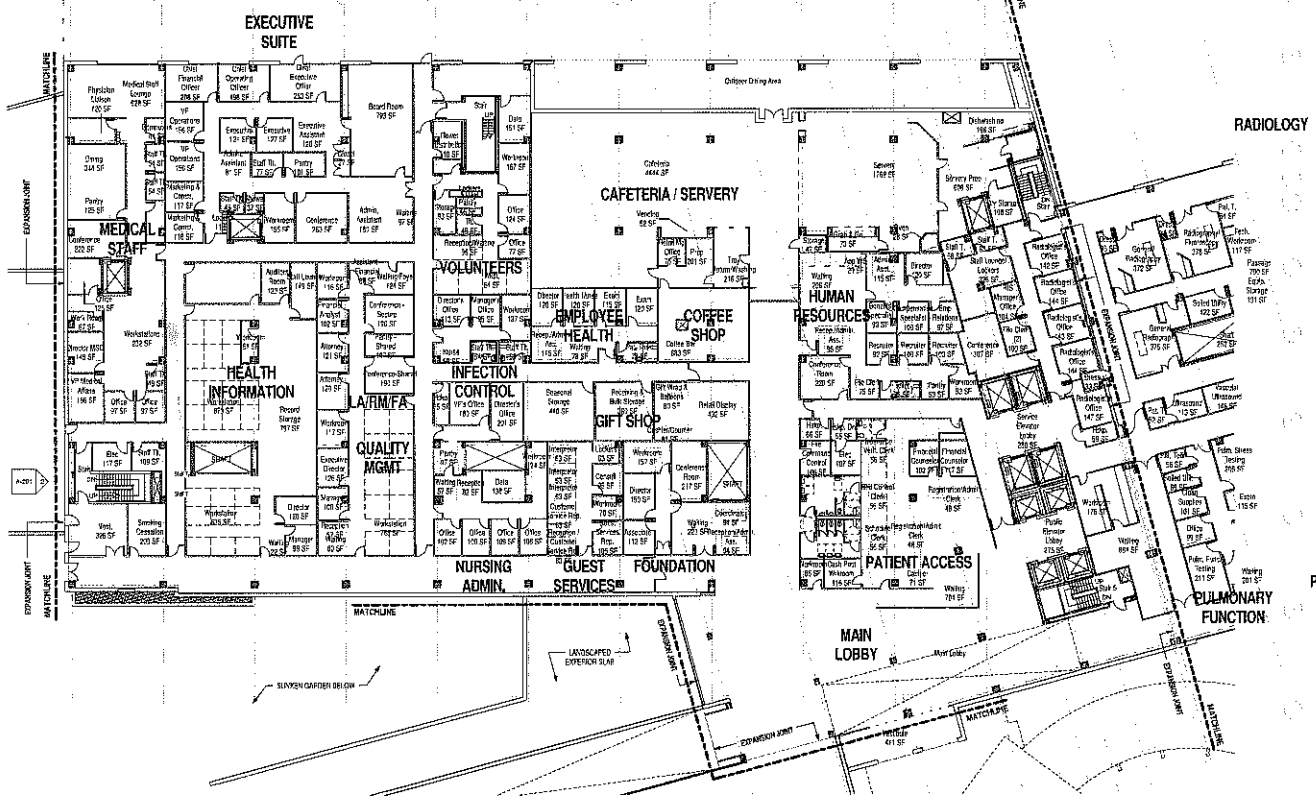
Last Revision:	

A-111



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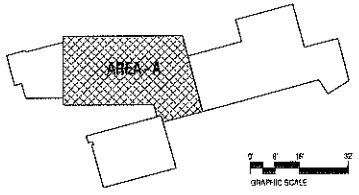

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Loiederman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lynch Wallace Associates, Inc., Elkridge, MD
Copley & Associates, Rockville, MD
Pennoni Planning & Zoning, Inc., Rockville, MD
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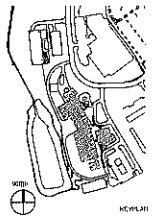

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Washington Adventist Hospital Replacement Project

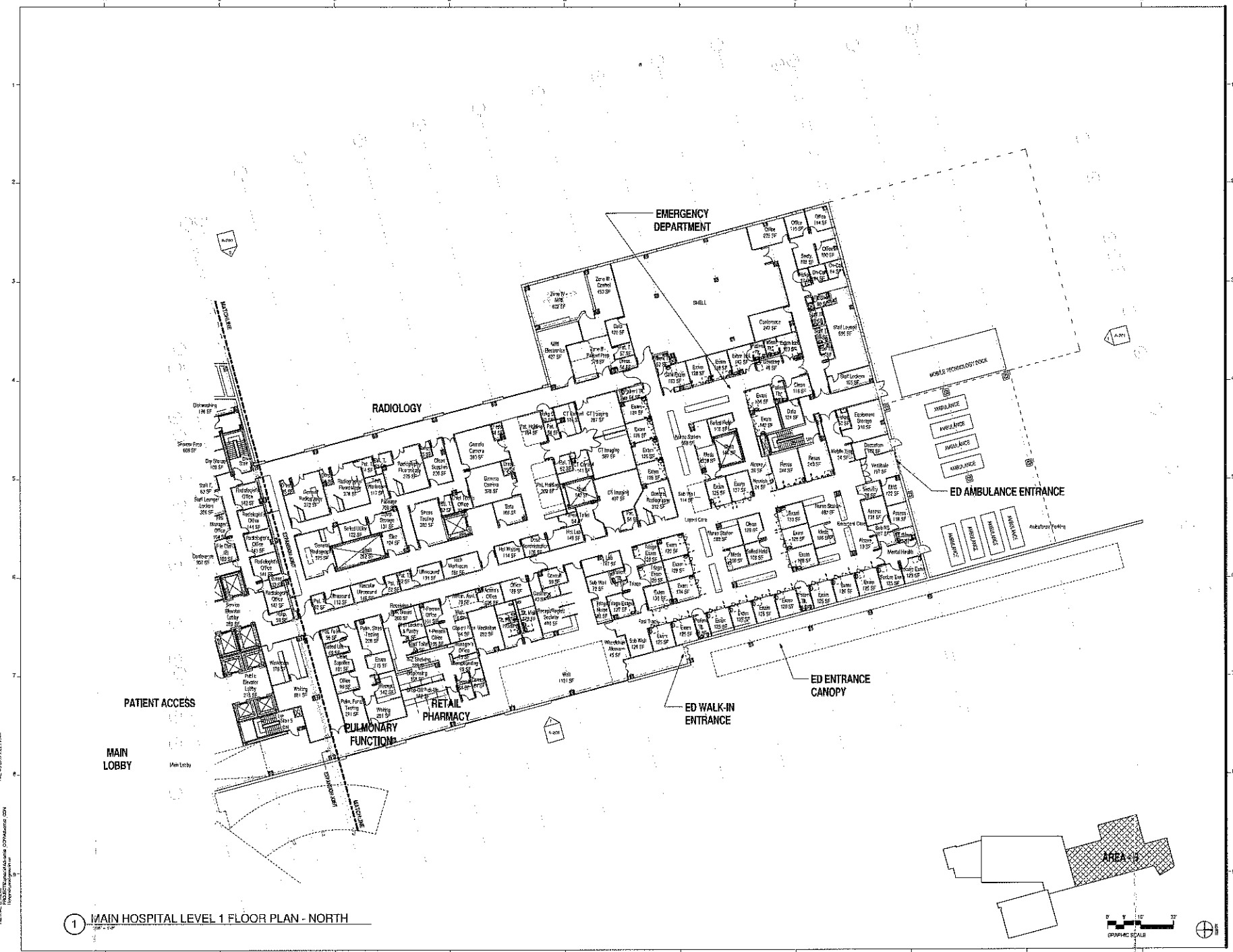
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

MAIN HOSPITAL LEVEL 1 FLOOR PLAN - SOUTH

Scale:	As Indicated
RTKL Contract No.	26-07011.01
Issue Date:	04.10.2009
Last Revision:	

A-111A



1 MAIN HOSPITAL LEVEL 1 FLOOR PLAN - NORTH

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lolodermon Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Copley & Associates, Rockville, MD
Perrina Planning & Zoning, Inc., Rockville, MD
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Washington Adventist Hospital Replacement Project

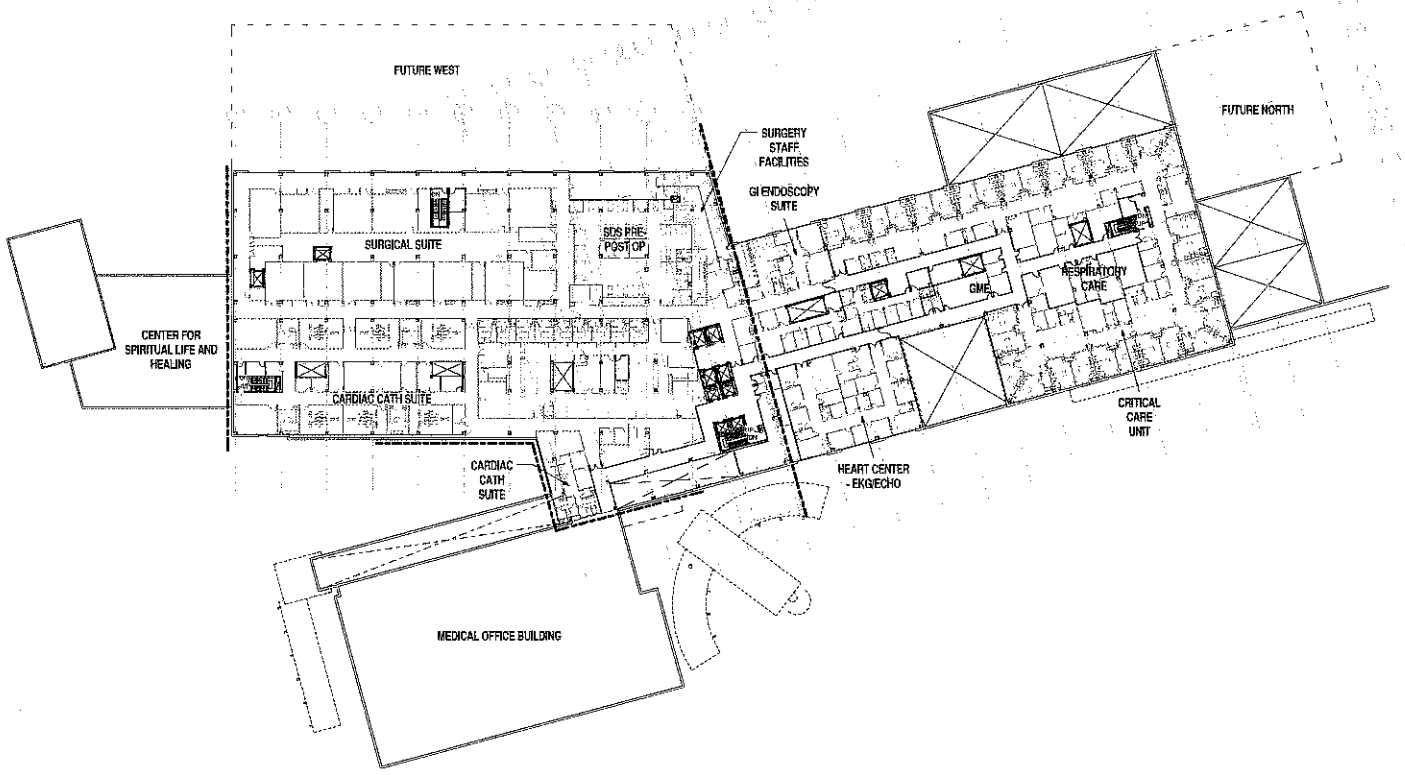
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

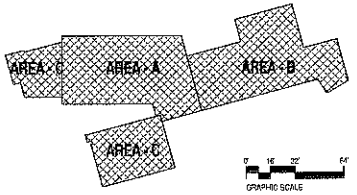
MAIN HOSPITAL LEVEL 1 FLOOR PLAN - NORTH

Scale:	As Indicated
RTKL Contract No.	20-07911.01
Issue Date:	04.19.2006
Last Revision:	

A-111B



1 LEVEL 2 FLOOR PLAN - OVERALL



Washington Adventist Hospital

CONTACT:
Geoffroy A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
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Loech Wallace Associates, Inc., Bledgo, MD
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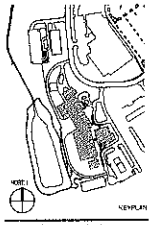

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Washington Adventist Hospital Replacement Project

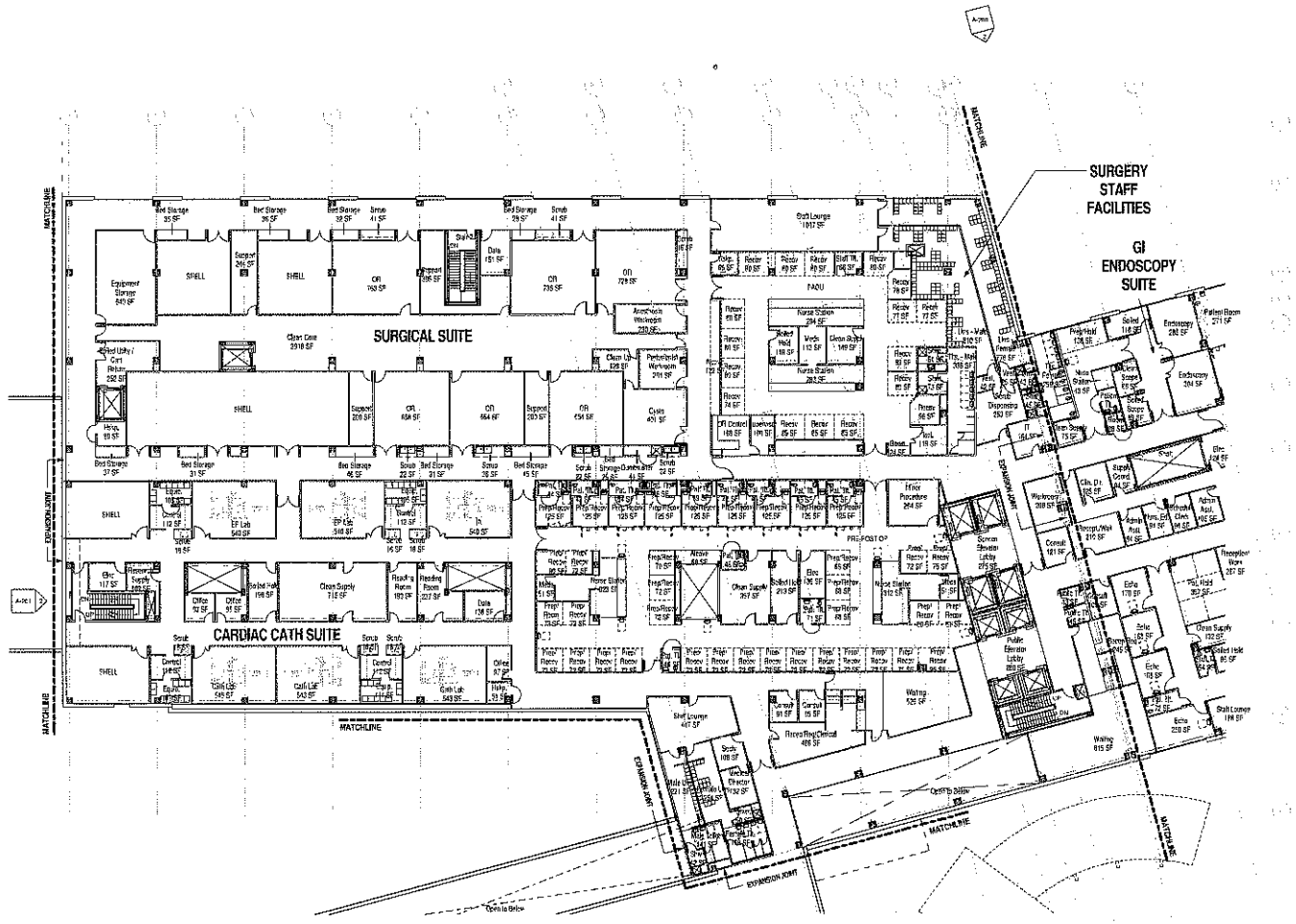
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

LEVEL 2 FLOOR PLAN

Scale: 1/32" = 1'-0"
RTKL Contract No. 20-07011.01
Issue Date: 04.16.2009
Last Revision:

A-112



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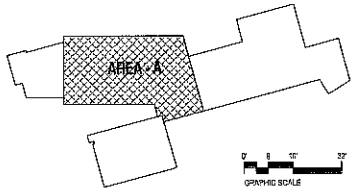

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lobsenz-Stolzer Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pentera Planning & Zoning, Inc., Rockville, MD
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PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

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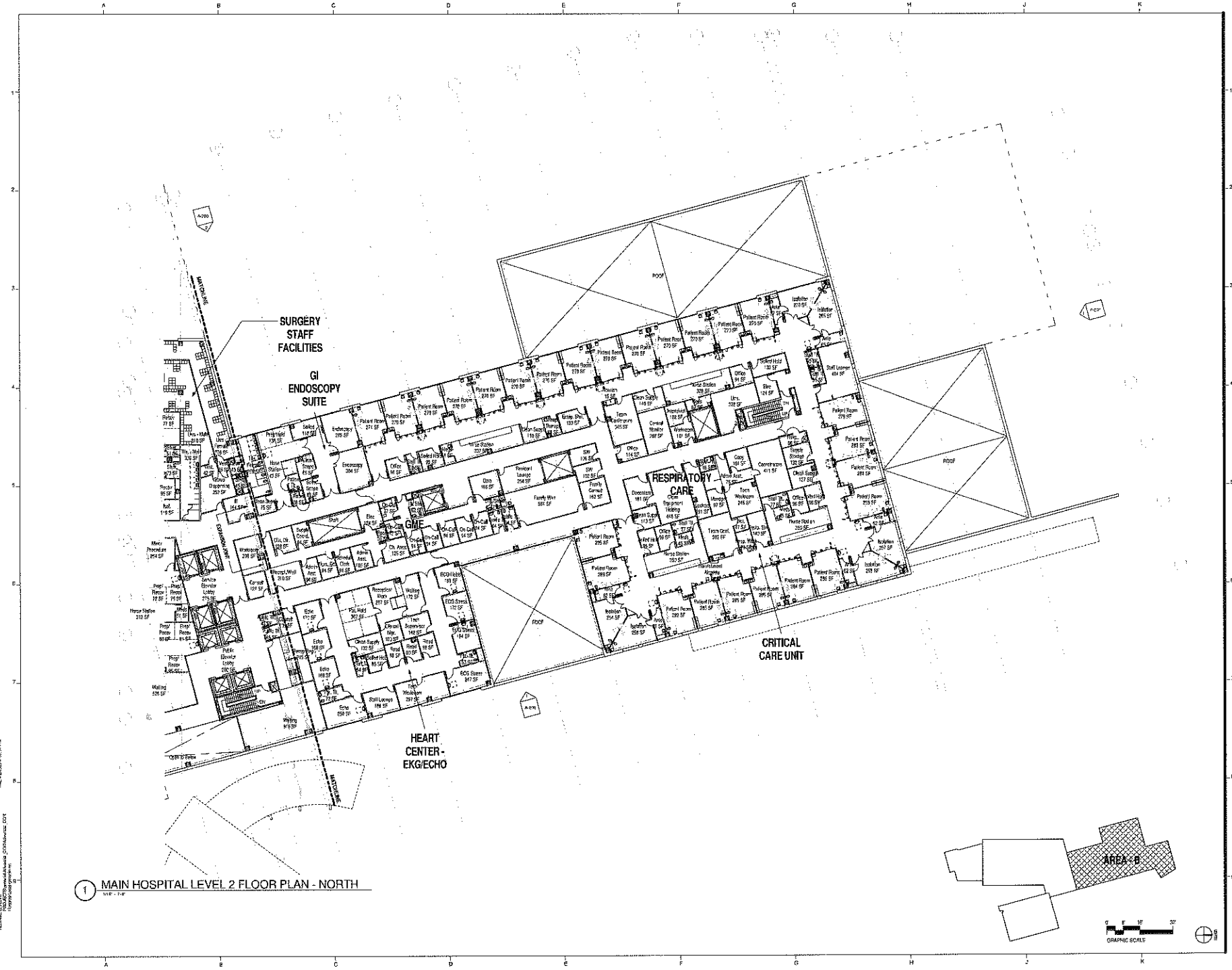
MAIN HOSPITAL LEVEL 2 FLOOR PLAN - SOUTH

Scale:	As Indicated
RTKL Contract No.	20-07911.01
Issue Date:	04.16.2008
Last Revision:	

A-112A



1 MAIN HOSPITAL LEVEL 2 FLOOR PLAN - NORTH

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5456

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lobsdorman Sollosz Associates, Inc., Rockville, MD
Parker Rodriguez Inc. Alexandria, VA
Leach Wallace Associates, Inc., Edgewood, MD
Cagley & Associates, Rockville, MD
Persise Planning & Zoning, Inc., Rockville, MD
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Washington Adventist Hospital Replacement Project

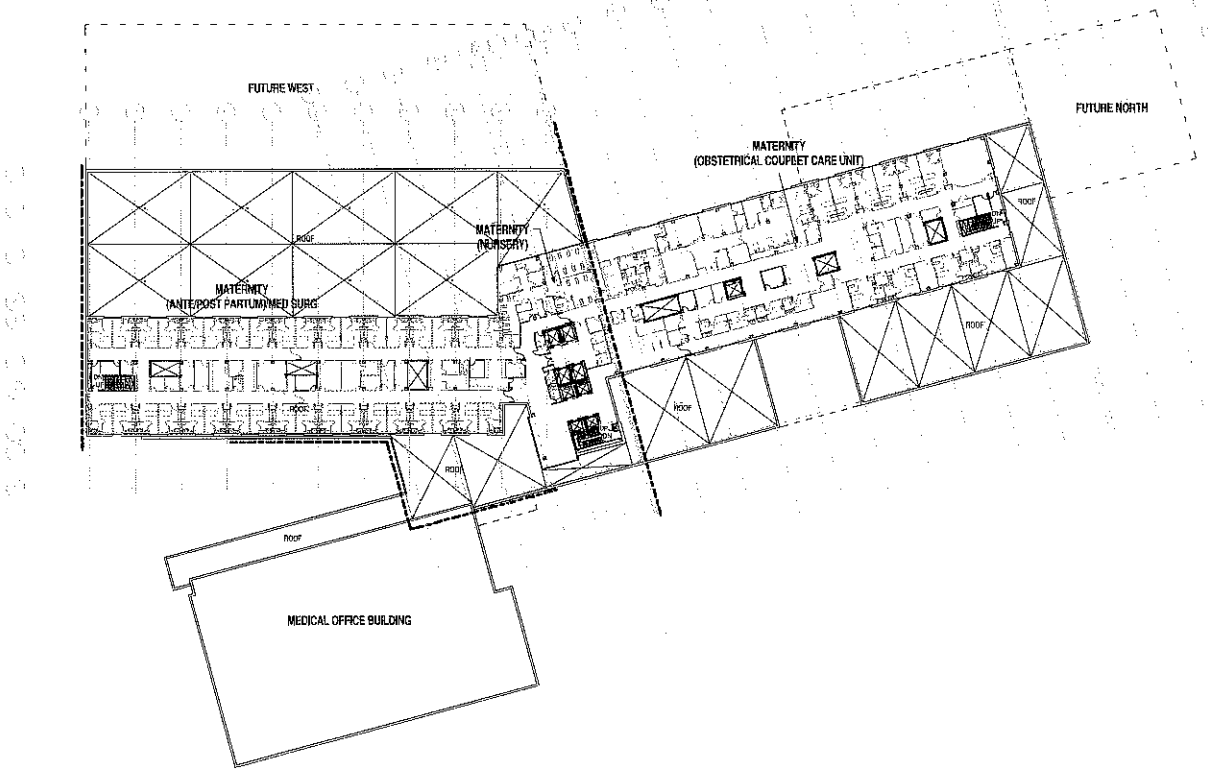
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

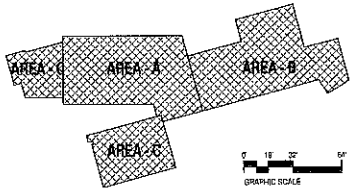
MAIN HOSPITAL LEVEL 2 FLOOR PLAN - NORTH

Scale:	As Indicated
RTKL Contract No.	20-07911.01
Issue Date:	04.10.2009
Last Revision:	

A-112B



1 LEVEL 3 FLOOR PLAN - OVERALL



Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5498

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lobsdorman Sollosz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
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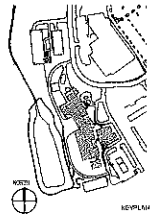

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Washington Adventist Hospital Replacement Project

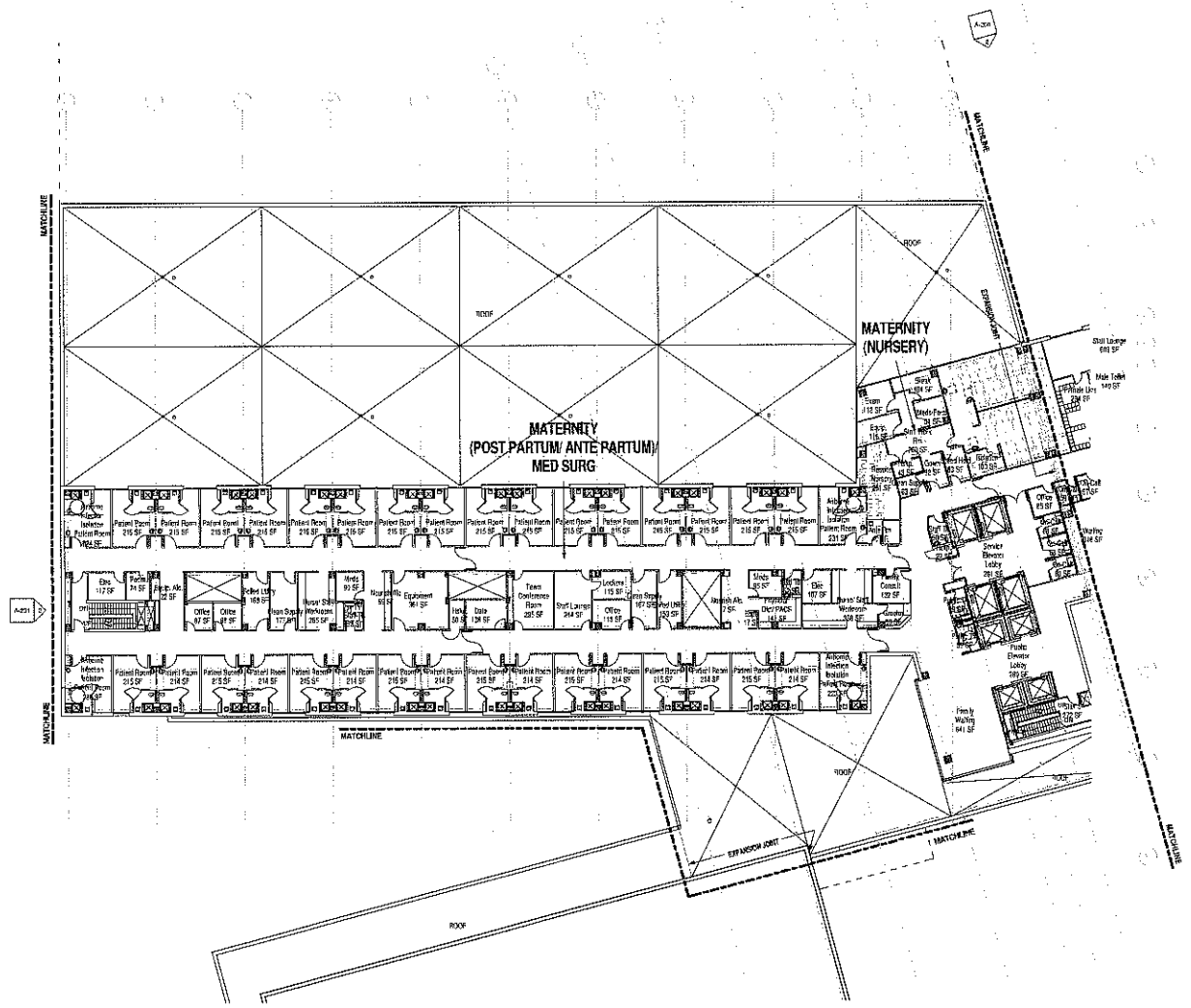
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

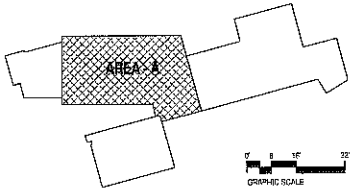
LEVEL 3 FLOOR PLAN

Scale:	1/32" = 1'-0"
RTKL Contract No.	20-07611.01
Issue Date:	04.10.2009
Last Revision:	

A-113



1 MAIN HOSPITAL LEVEL 3 FLOOR PLAN - SOUTH



Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lolodermon Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pentine Planning & Zoning, Inc., Rockville, MD
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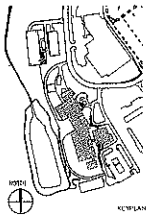

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Washington Adventist Hospital Replacement Project

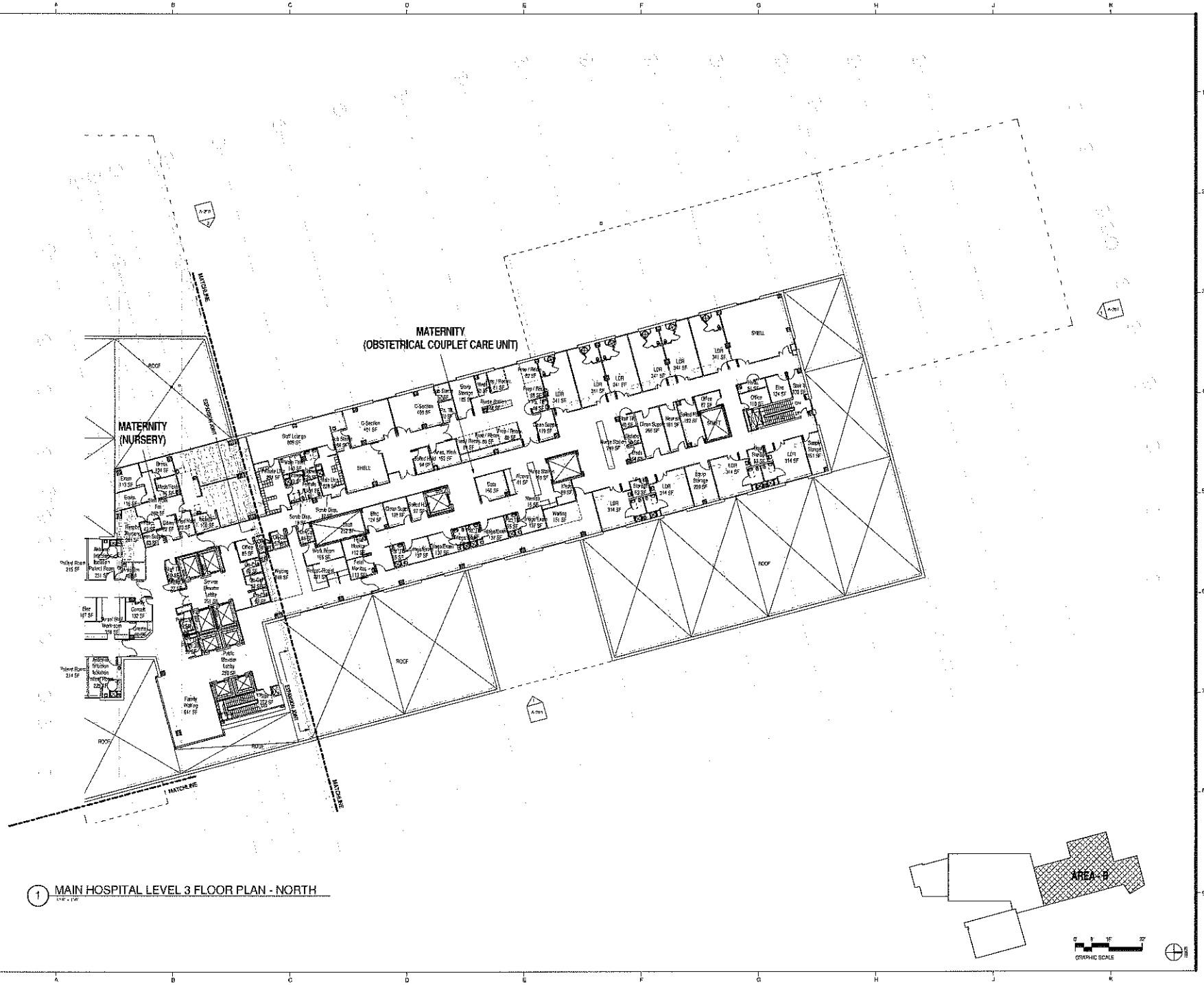
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

MAIN HOSPITAL
LEVEL 3 FLOOR PLAN
- SOUTH

Scale:	As Indicated
RTKL Contract No.	20-07011.01
Issue Date:	04.10.2008
Last Revision:	

A-113A



1 MAIN HOSPITAL LEVEL 3 FLOOR PLAN - NORTH

1/16" = 1'-0"

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Loiederman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Persico Planning & Zoning, Inc., Rockville, MD
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The Walker Group LLC, Bethesda, MD
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Holland & Knight LLP, Bethesda, MD
LaSalle Engineering, LLC, Willow Grove, PA

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Washington Adventist Hospital Replacement Project

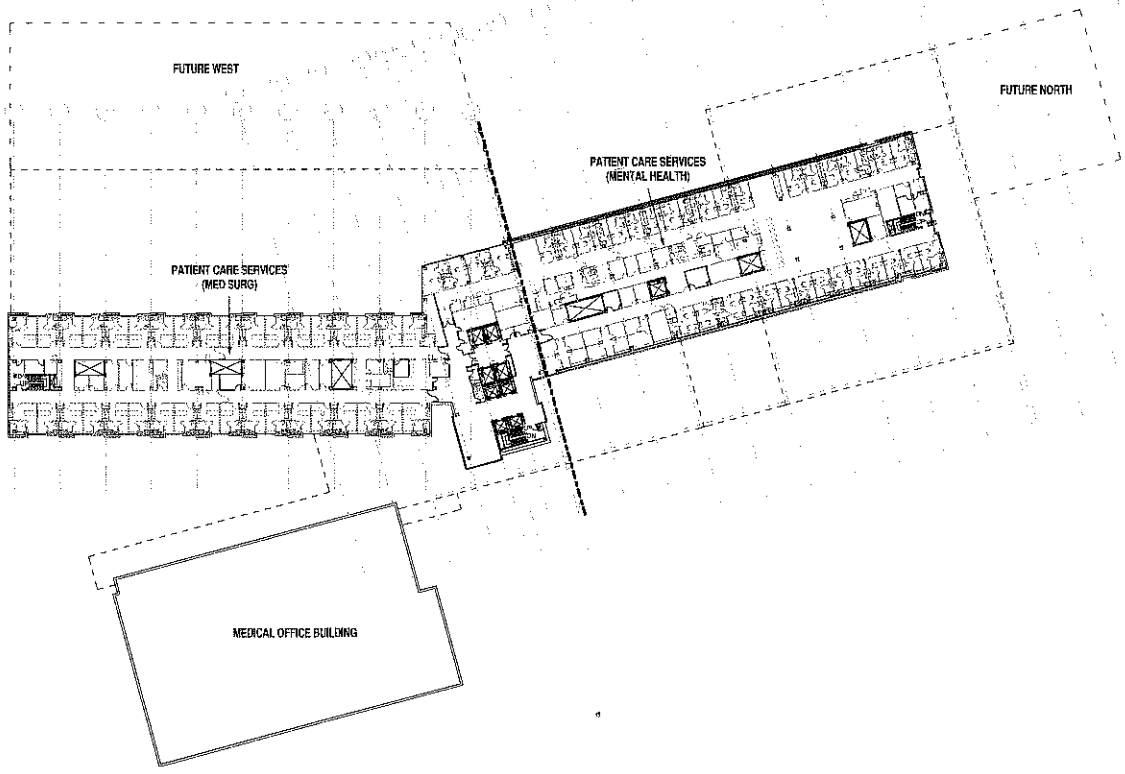
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

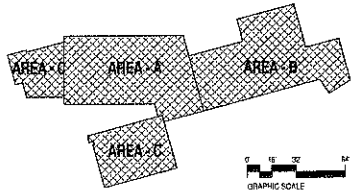
MAIN HOSPITAL
LEVEL 3 FLOOR PLAN
- NORTH

Scale:	As Indicated
RTKL Contract No.	20-0701.01
Issue Date:	04.10.2009
Last Revision:	

A-113B



1 LEVEL 4 FLOOR PLAN - OVERALL



Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lolodermon Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Copley & Associates, Rockville, MD
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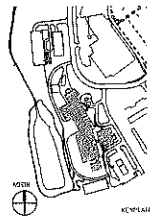

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Washington Adventist Hospital Replacement Project

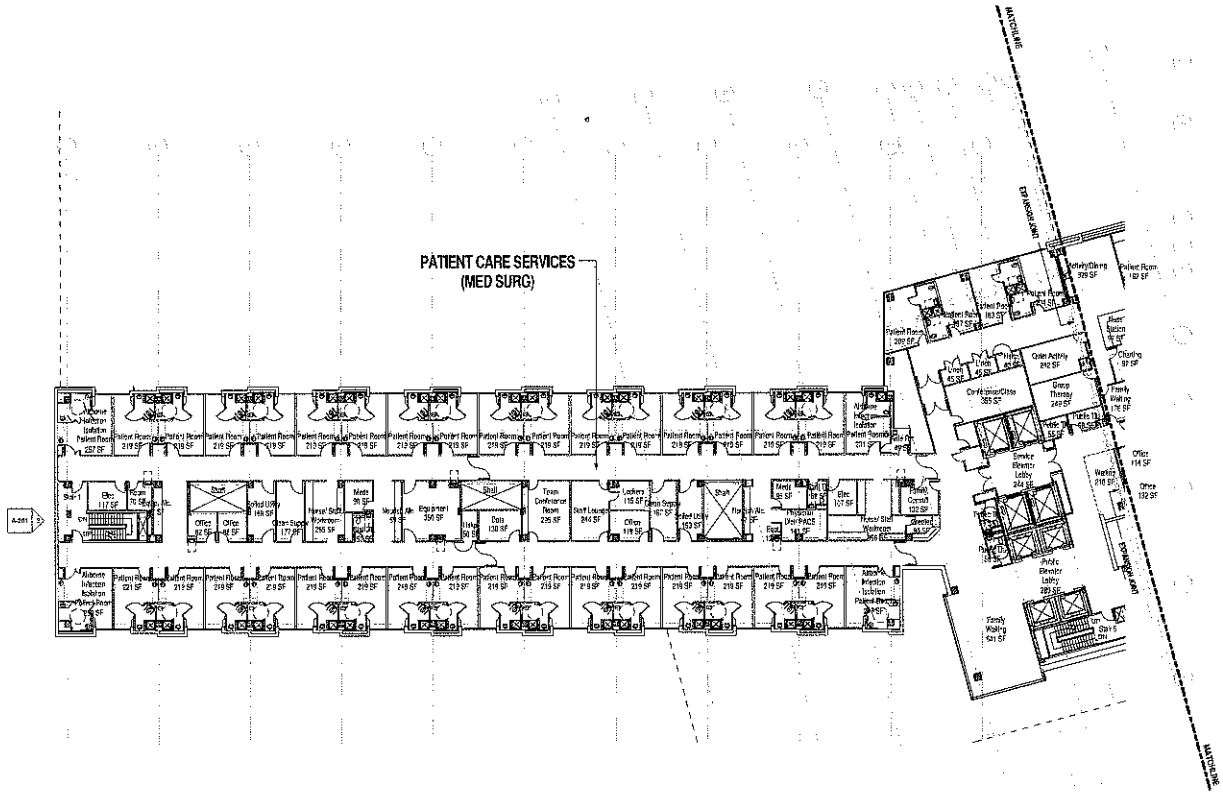
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

LEVEL 4 FLOOR PLAN

Scale:	1/32" = 1'-0"
RTKL Contract No.	29-07911.01
Issue Date:	04.10.2009
Last Revision:	

A-114



Washington Adventist Hospital

CONTACT:
Geoffrey A. Meagor
Vice President
Washington Adventist Hospital
301.891.5455

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Loladerman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
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Cagley & Associates, Rockville, MD
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LaSalle Engineering, LLC, Willow Grove, PA

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

MAIN HOSPITAL LEVEL 4 FLOOR PLAN - SOUTH

Scale:	As Indicated
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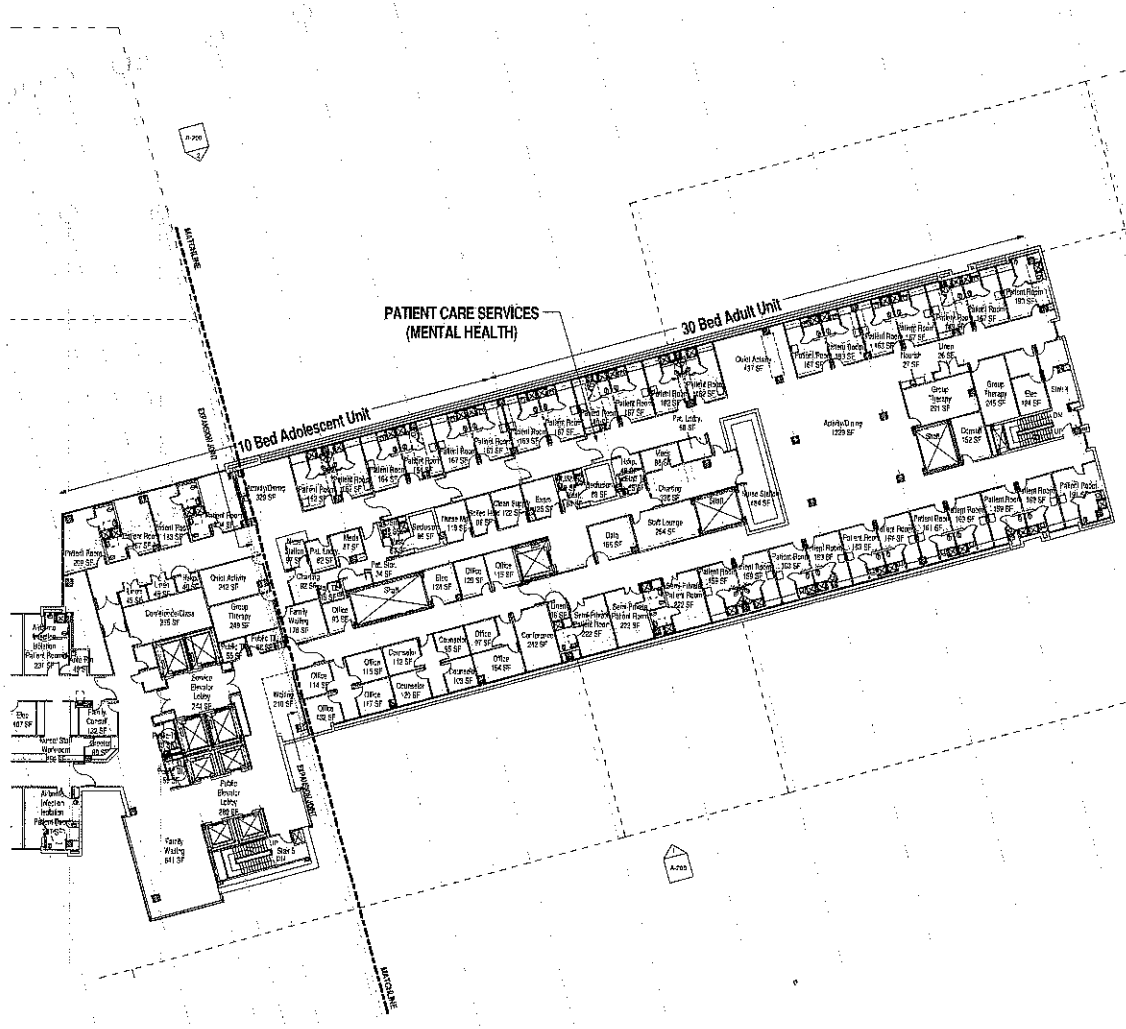
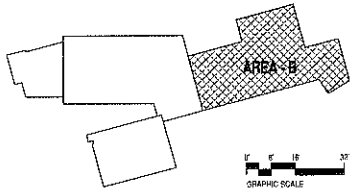
Issue Date:	04.10.2009
Last Revision:	

A-114A



1 MAIN HOSPITAL LEVEL 4 FLOOR PLAN - NORTH



Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5468

CONSULTANTS:
RTKL Associates, Inc., Washington, DC
Loiederman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
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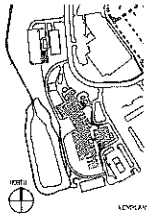

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

MAIN HOSPITAL LEVEL 4 FLOOR PLAN - NORTH

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Issue Date:	04.10.2009
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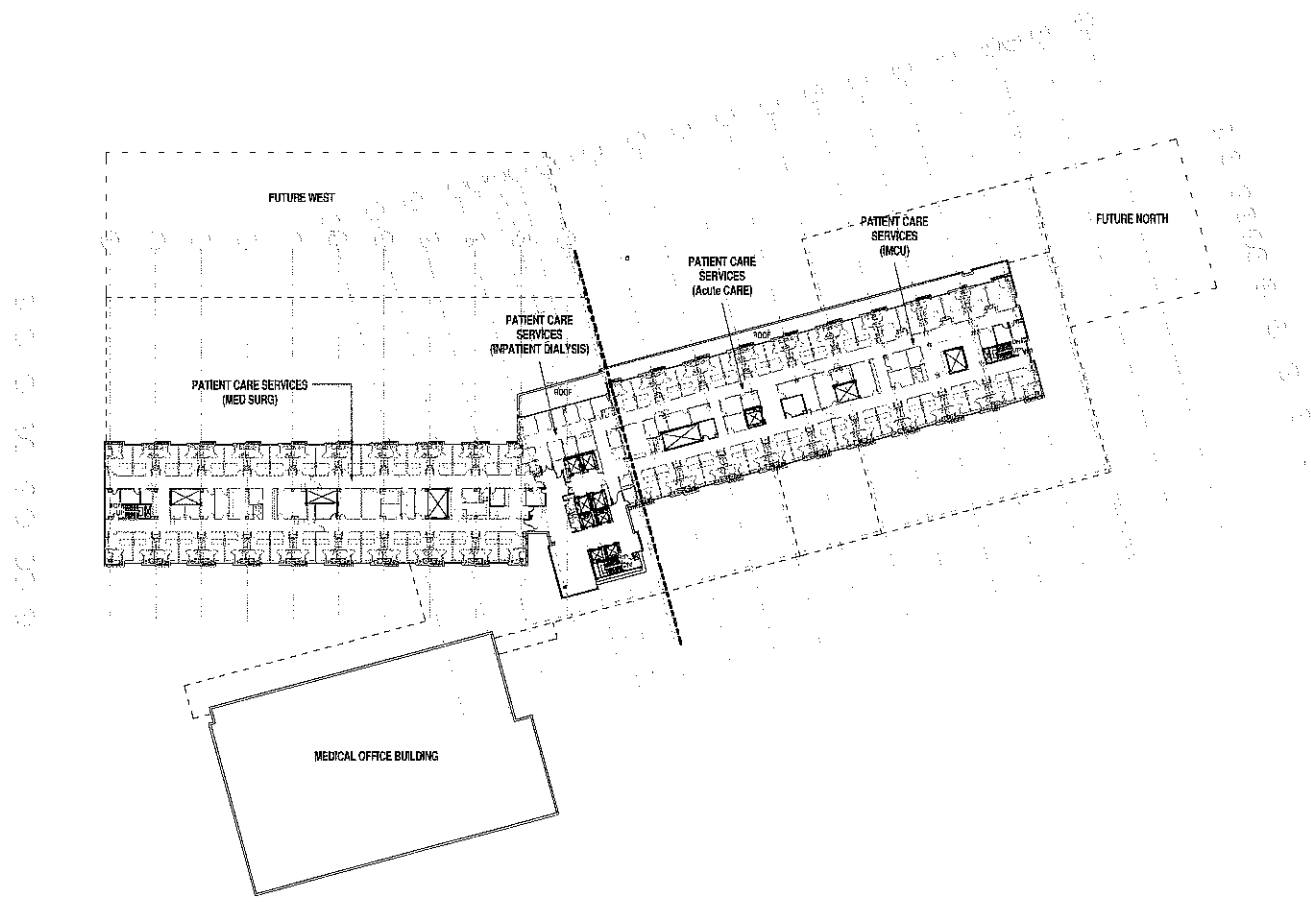
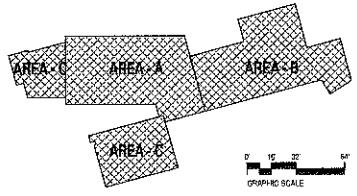
A-114B



1 LEVEL 5 FLOOR PLAN - OVERALL



Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5159

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lokelderman Sallese Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
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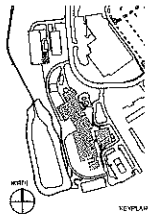

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
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CON APPLICATION

LEVEL 5 FLOOR PLAN

Scale:	1/32" = 1'-0"
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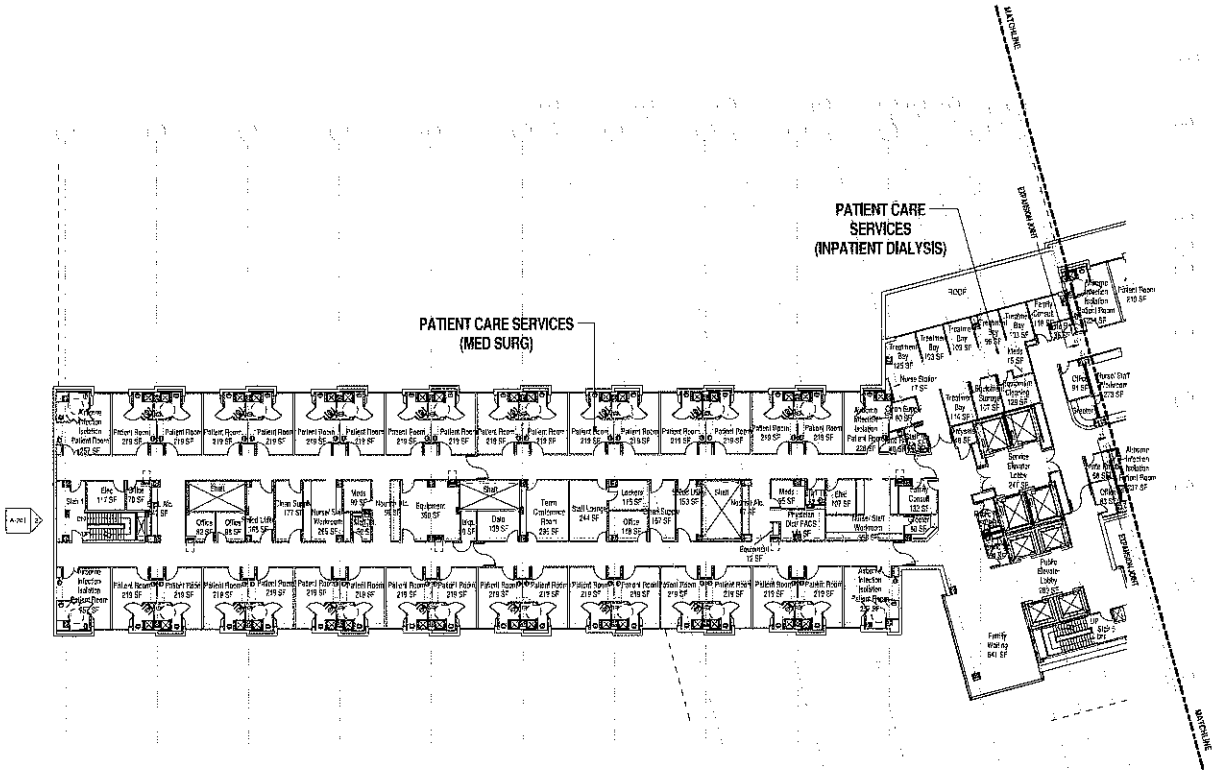
A-115



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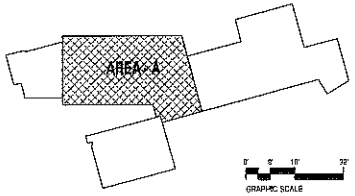

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lokenbman Sollins Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Persico Planning & Zoning, Inc., Rockville, MD
The Traffic Group, Inc., Baltimore, MD
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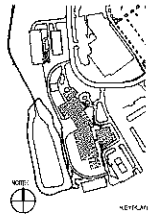

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Washington Adventist Hospital Replacement Project

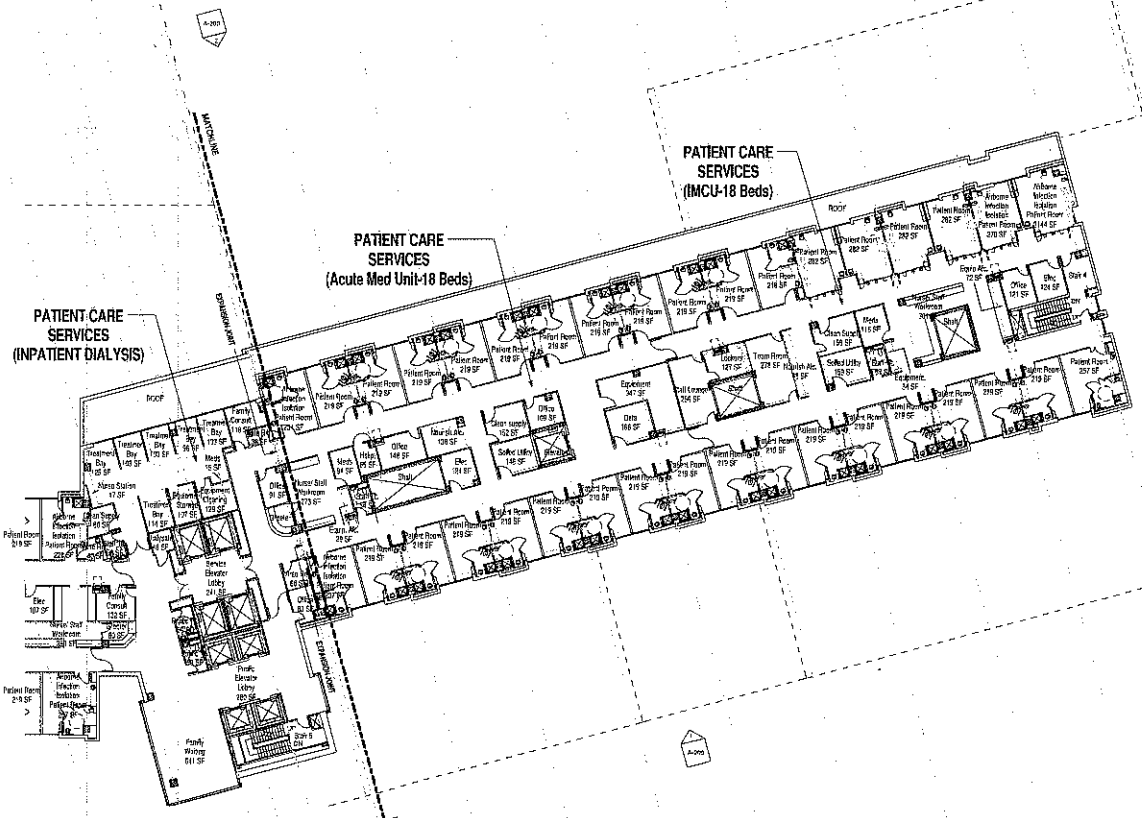
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

MAIN HOSPITAL LEVEL 5 FLOOR PLAN - SOUTH

Scale:	As Indicated
RTKL Contract No.	20-07011.01
Issue Date:	04.10.2009
Last Revision:	

A-115A



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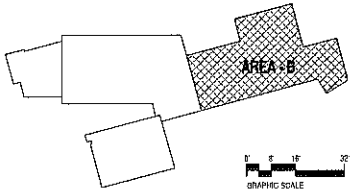

Washington Adventist Hospital

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Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

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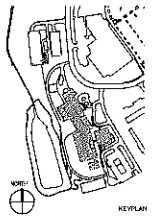

KEYPLAN

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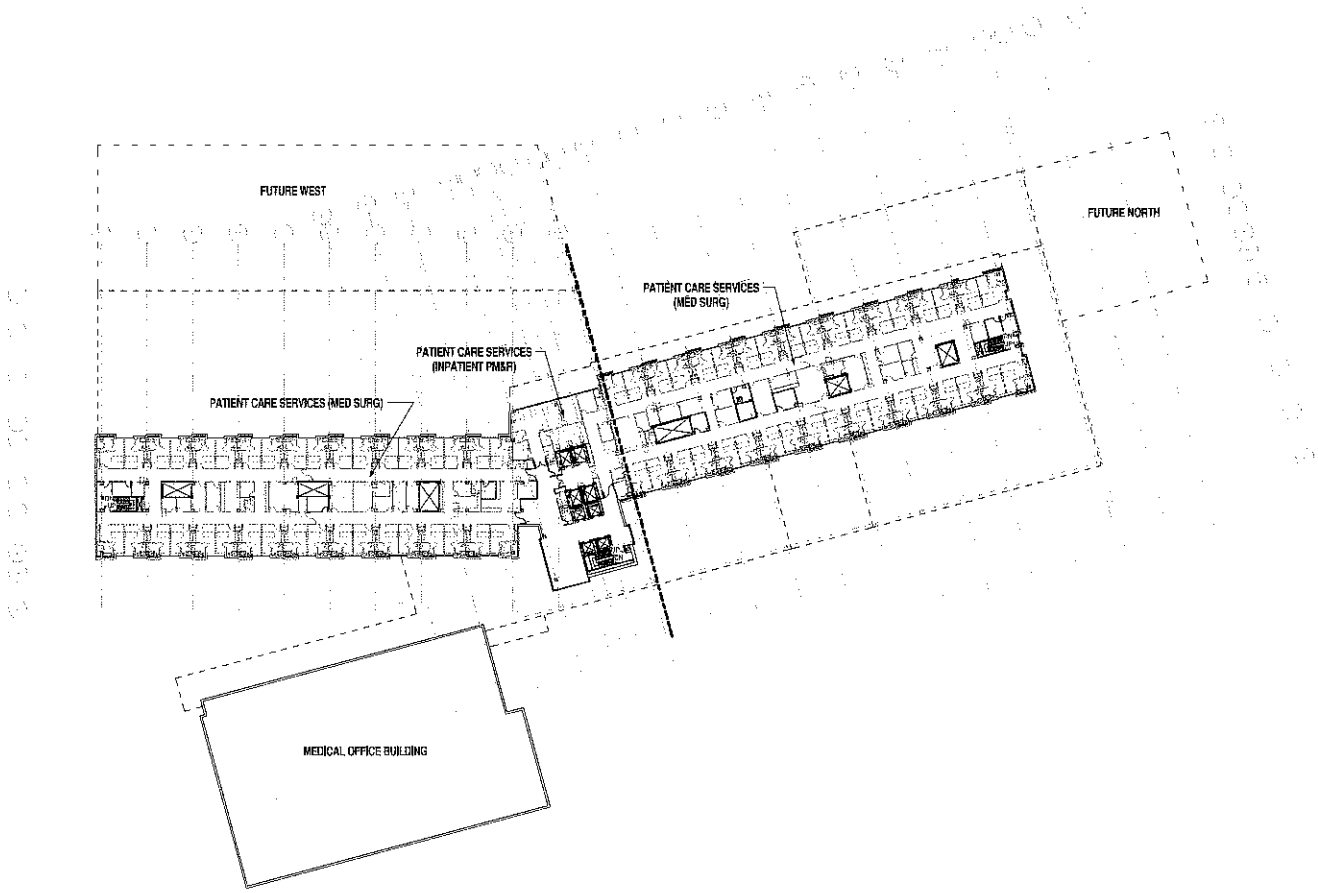
A-115B



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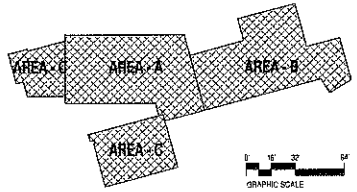

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

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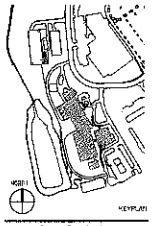

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
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LEVEL 6 FLOOR PLAN

Scale:	1/64" = 1'-0"
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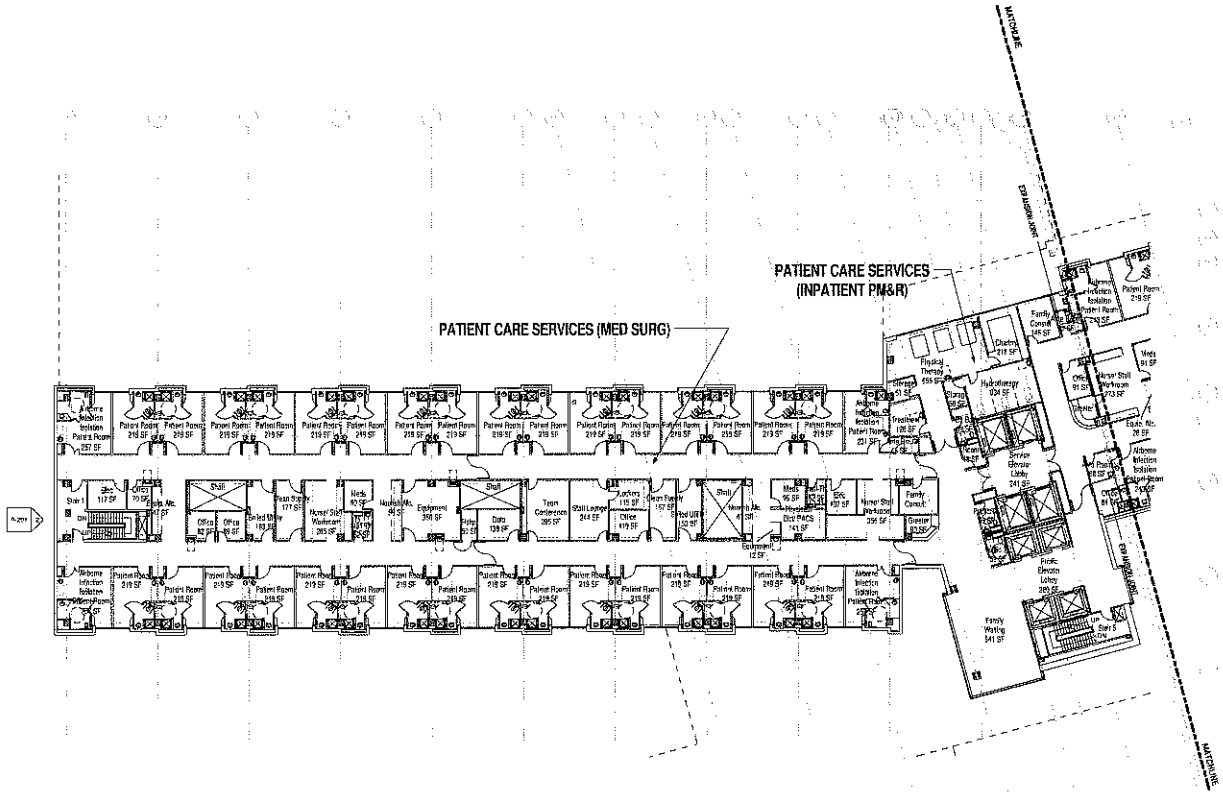
A-116



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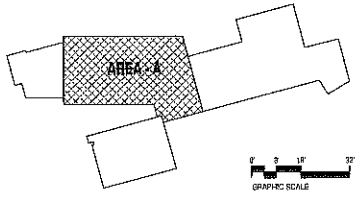

Washington Adventist Hospital

CONTACT
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5456

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lalodermen-Safnoss Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lench Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
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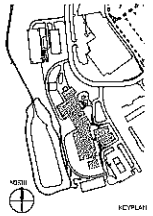

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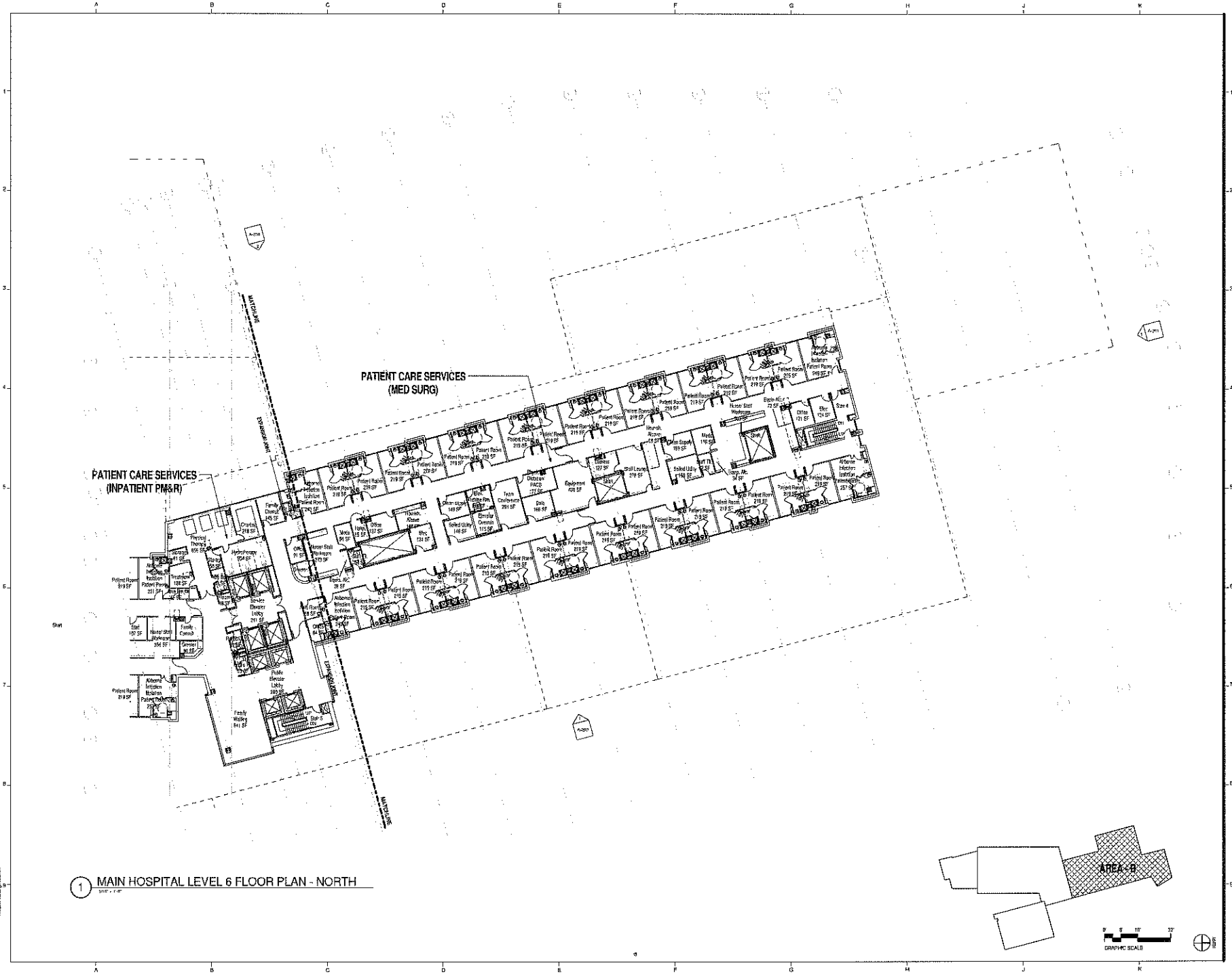
A-116A



1 MAIN HOSPITAL LEVEL 6 FLOOR PLAN - NORTH

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lederman Stilacci Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lynch Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Persico Planning & Zoning, Inc., Rockville, MD
The Traffic Group, Inc., Baltimore, MD
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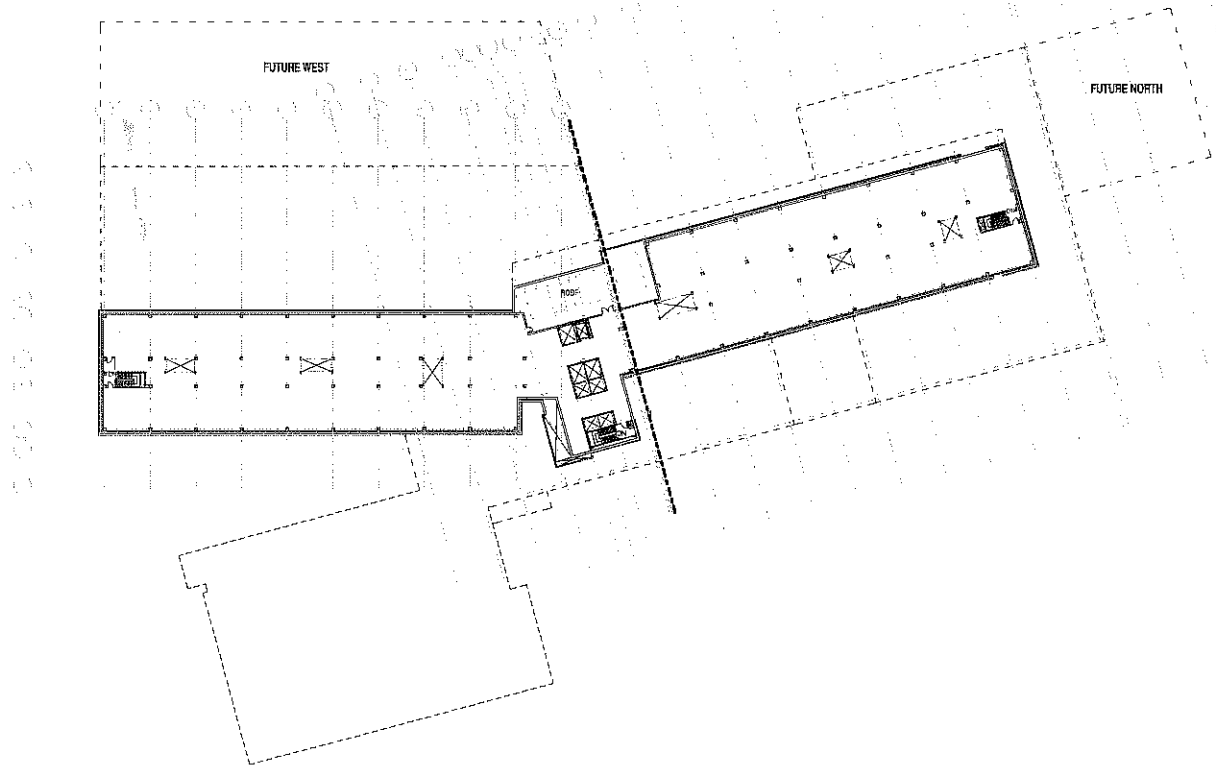

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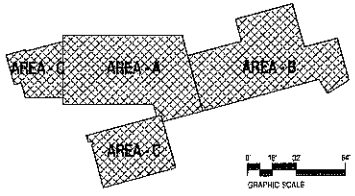

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5468

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Loiderman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lenoch Wallace Associates, Inc., Elkridge MD
Cagley & Associates, Rockville, MD
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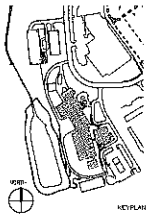

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Washington Adventist Hospital Replacement Project

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SILVER SPRING, MARYLAND 20904

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PENTHOUSE LEVEL FLOOR PLAN

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RTKL Contract No.	20-07011.01
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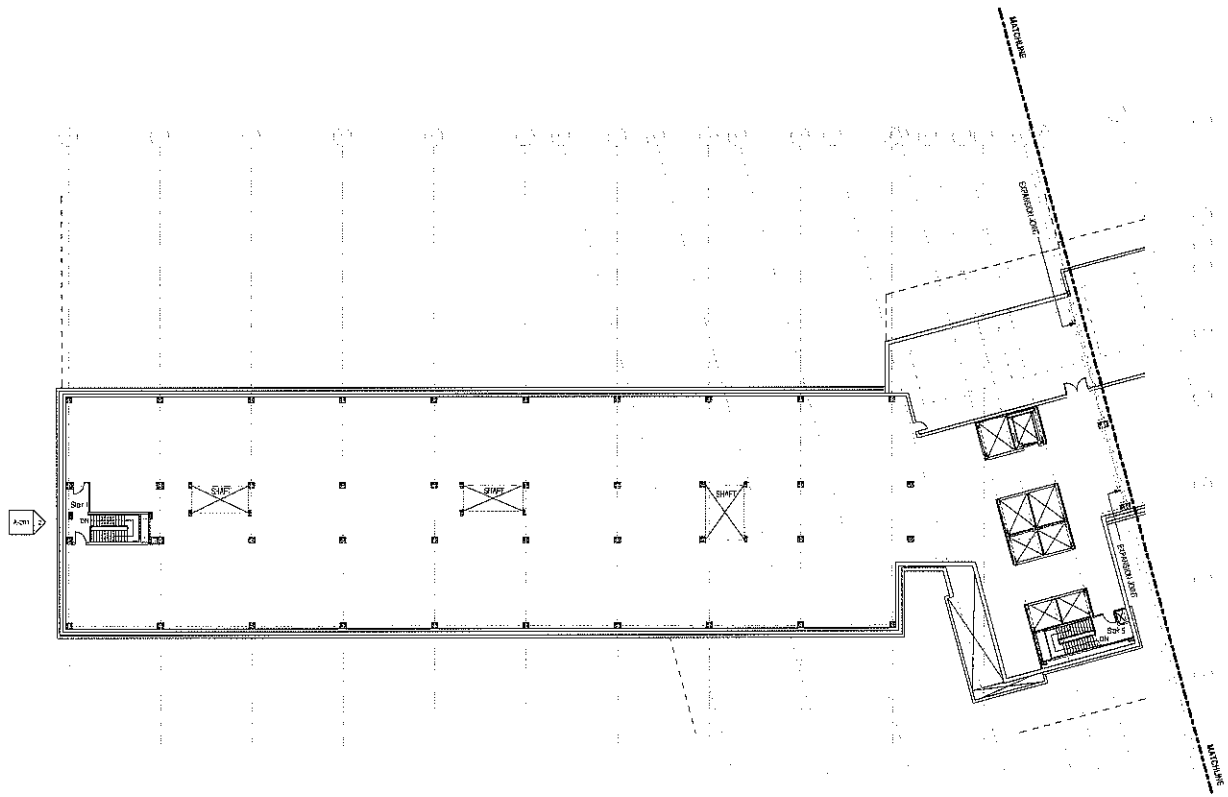
A-118



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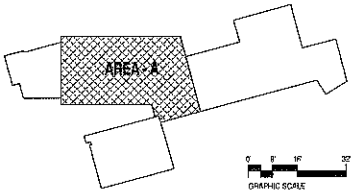

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5459

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Lolederman Soltesz Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Dagley & Associates, Rockville, MD
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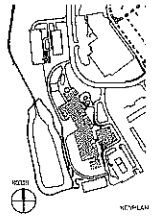

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

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PENTHOUSE OPTION
FLOOR PLAN - SOUTH

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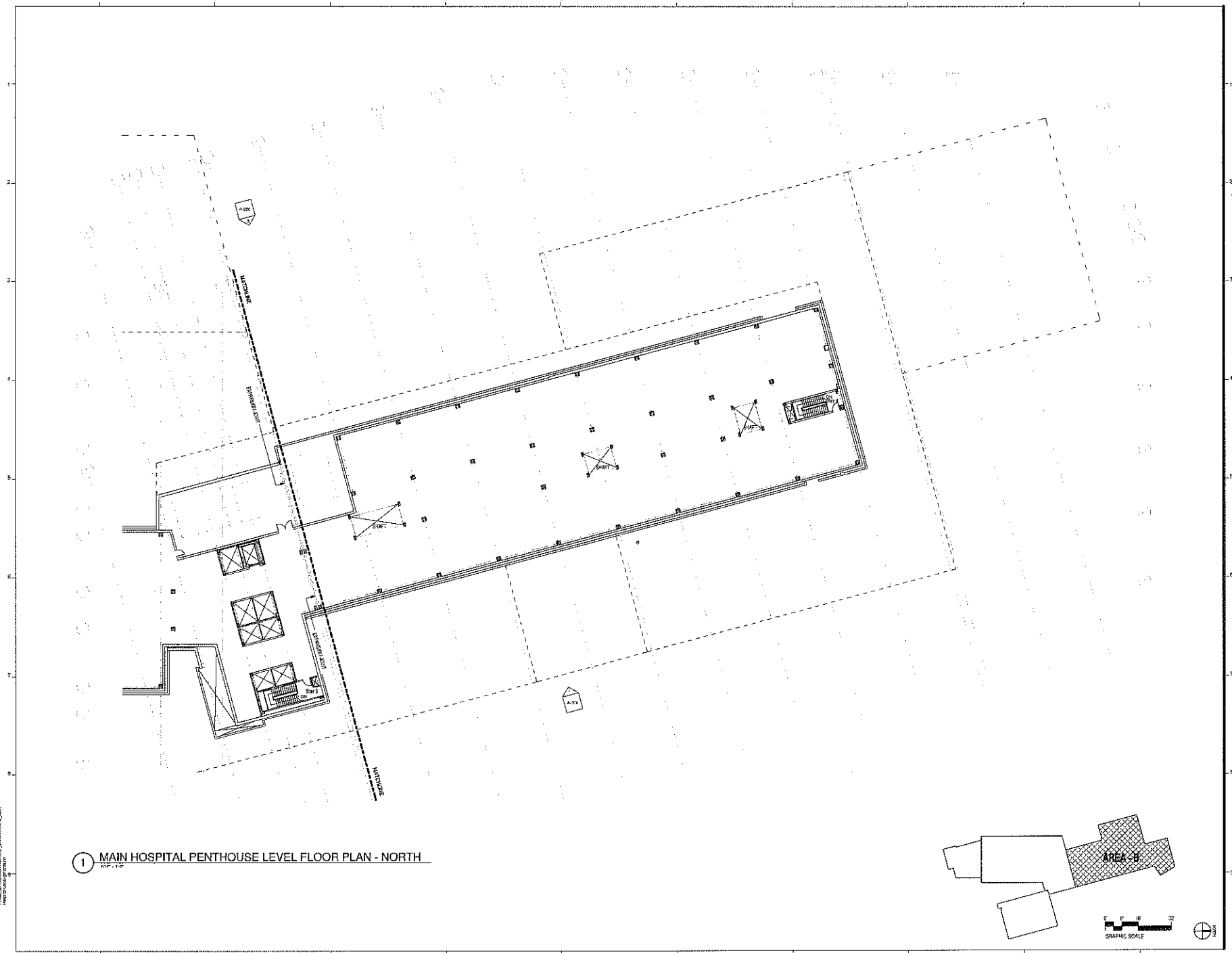

1 MAIN HOSPITAL PENTHOUSE LEVEL FLOOR PLAN - NORTH

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5459

CONSULTANTS:
RTKL Associates, Inc. Washington, DC
Kaiserman Salitsky Associates, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Lynch Watson Associates, Inc., Elkridge MD
Cagley & Associates, Rockville, MD
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SILVER SPRING, MARYLAND 20904

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PENTHOUSE OPTION
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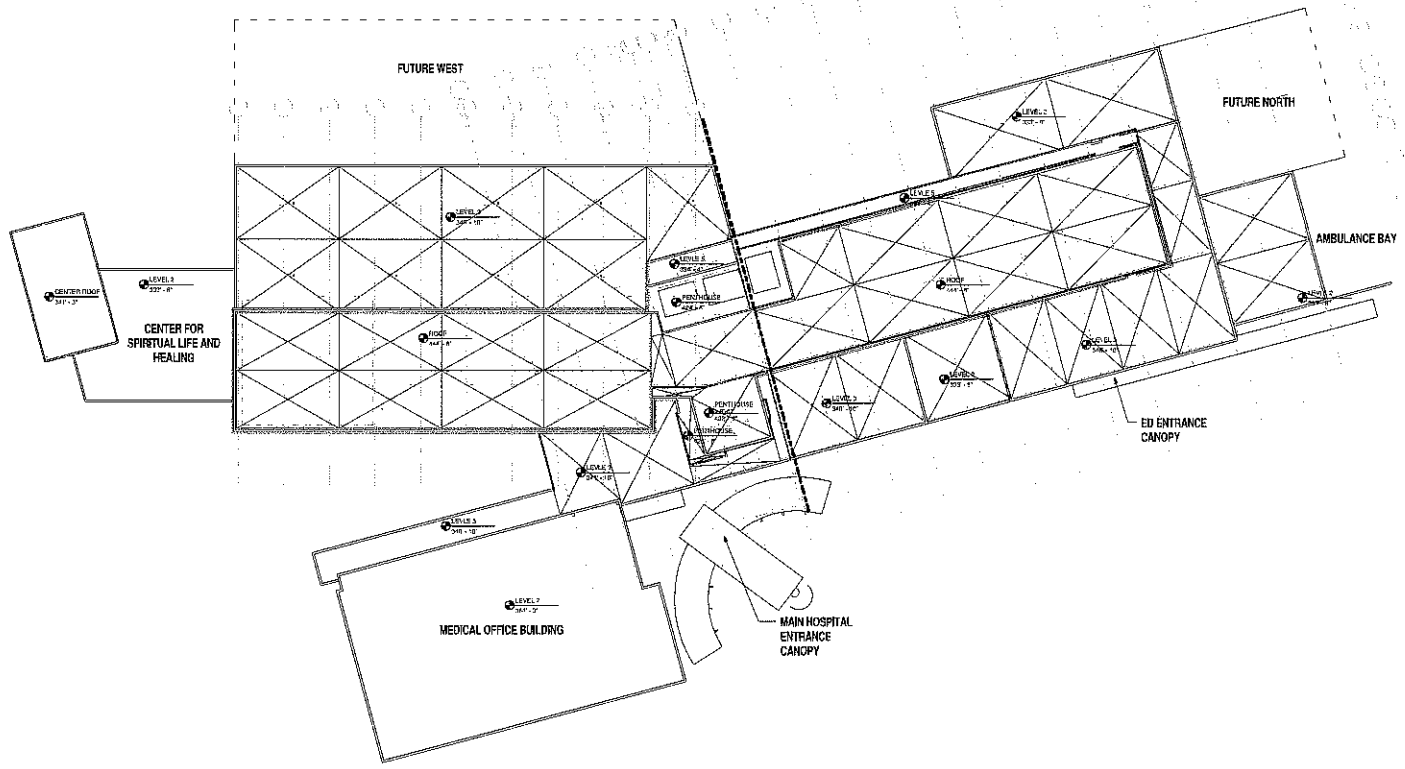

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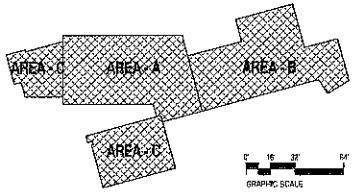

Washington Adventist Hospital

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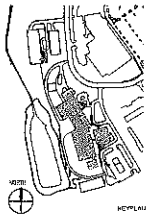

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ROOF FLOOR PLAN

Scale:	1/32" = 1'-0"
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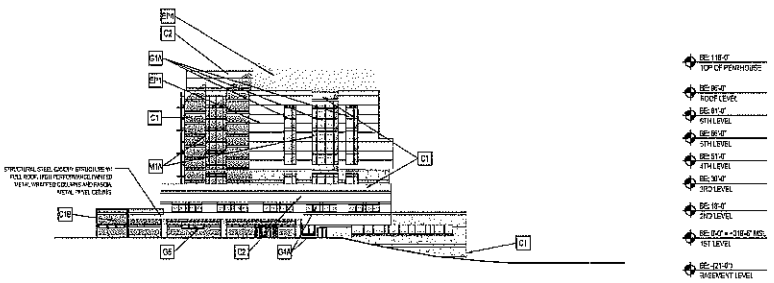
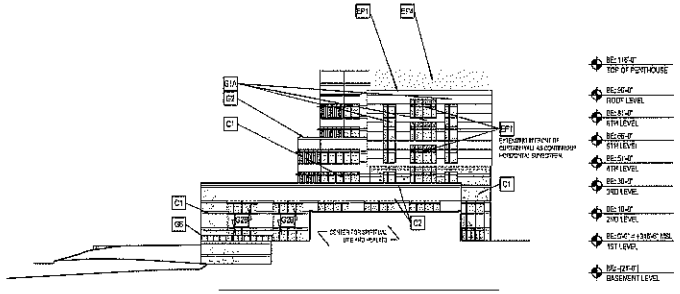


1 NORTH ELEVATION - MAIN HOSPITAL



1 SOUTH ELEVATION - MAIN HOSPITAL

MATERIAL LEGEND

- C1 — ARCHITECTURAL SPLIT FACE CMU
- C1B — ARCHITECTURAL SPLIT FACE CMU
- C2 — ARCHITECTURAL PRECAST AC
- EP1 — POLYMER BASED SOLID PHENOLIC EXTERIOR WALL
- EP2 — COMPOSITE ALUMINUM METAL PANEL SYSTEM
- EP3 — COMPOSITE ALUMINUM METAL PANEL SYSTEM
- EP4 — PENTHOUSE FIBER CEMENT WALL SYSTEM PAINTED
- G1A — ALUMINUM CURTAINWALL WINDOW
- G1B — ALUMINUM CURTAINWALL WINDOW
- G2 — ALUMINUM CURTAINWALL WINDOW SYSTEM
- G2B — ALUMINUM CURTAINWALL WINDOW SYSTEM
- G2C — ALUMINUM CURTAINWALL WINDOW SYSTEM
- G3 — ALUMINUM DIRECT-GLAZE WINDOW SYSTEM
- G4A — PERIMETER ALUMINUM WINDOW SYSTEM
- G4B — PERIMETER ALUMINUM WINDOW SYSTEM
- G5 — PERIMETER ALUMINUM WINDOW SYSTEM
- G6 — TOOD CENTER VIEWING GLASS CURTAINWALL SYSTEM
- L1 — ARCHITECTURAL LOUVERS
- M1A — PAINTED ALUMINUM PANEL SYSTEM
- M1B — PAINTED ALUMINUM VERTICAL SUNSHADE
- M2 — METAL CANOPIES

MATERIAL LEGEND ABBREVIATIONS:
GRG - GLASS REINFORCED GYPSUM
CP - CURTAINWALL PANEL SYSTEM
G - GLAZING SYSTEM
L - LOUVER SYSTEM
M - METAL/CURTAINWALL SYSTEM

ALTERNATES:
C1 - ARCHITECTURAL PRECAST, WITH BOSH TEXTURE FINISH
C1 - ARCHITECTURAL PRECAST, WITH PAINT FINISH

Washington Adventist Hospital

CONTACT:
Geoffrey A. Morgan
Vice President
Washington Adventist Hospital
301.891.5458

CONSULTANTS:
RTKL Associates, Inc., Washington, DC
Lichtenstein Consulting Engineers, Inc., Rockville, MD
Parker Rodriguez Inc., Alexandria, VA
Leach Wallace Associates, Inc., Elkridge, MD
Cagley & Associates, Rockville, MD
Pumpian Planning & Zoning, Inc., Rockville, MD
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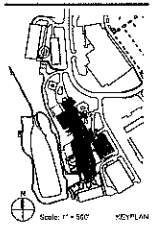

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Washington Adventist Hospital Replacement Project

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

CON APPLICATION

Main Building
North Elevation
South Elevation

Scale:	As Indicated
RTKL Contract No.	20-07011.03
Issue Date	04/10/2009
Last Revision	

A-201

Attachment 10

Psych written discharge planning policies

WASHINGTON ADVENTIST HOSPITAL
PATIENT CARE POLICY MANUAL

INTERDISCIPLINARY CARE & DISCHARGE PLANNING

Effective Date: 11/82 **Policy No: WAH. 5921**
Cross Referenced: 5564, 5852, 5922 Origin: NRSG
Reviewed: 3/87, 3/88, 4/89, 5/90, 6/98 Authority: SM
Revised: 1/86, 2/91, 5/92, 6/95, 7/95, 5/01, 1/04 ,7/04, 6/06

SCOPE

All Patient Care Areas

PURPOSE

To describe the discharge planning process and the responsibilities of the members of the patient care team in implementing the discharge planning process.

POLICY

Discharge planning is the process whereby patient needs are identified and evaluated, and assistance is given in preparation for discharge from the Hospital.

GUIDELINES

In order to provide safe and timely continuity of care, discharge planning begins before or at the time of admission. The process is multi-disciplinary and takes into account the patient's right, in collaboration with his/her physician, to make decisions regarding his/her medical care, and involves the patient's family/significant other, when appropriate. Patients having one or more of the intervention parameters undergo more intensive planning efforts.

The preadmission information and screening identifies the needs of the patients so an interdisciplinary plan of care can be implemented and the patient can be treated in the most appropriate care setting.

The interdisciplinary plan of care is continually assessed and reassessed to address specific needs, including tests or procedures, referrals, treatments and therapies, and education.

Prior to discharge, an interdisciplinary team identifies patient needs relating to home services, ancillary services, or transfer to another facility. At discharge the patient is referred to practitioners, settings, and organizations to meet his or her continuing needs. If barriers are identified which prevent the patient from following the recommendation for a safe discharge, a reassessment will be completed.

DEFINITIONS

Intervention Parameters: Factors that might prolong the length of stay or complicate the discharge plan. These factors are established by a multi disciplinary discharge planning team, and include:

- Primary/Secondary diagnoses: Amputee, cancer with metastasis, CVA, HTN,

uncontrolled DM, HIV, change in mental status, mental health diagnosis, substance abuse, hip fracture, or multiple fractures which impact stability; such as: Parkinson's Disease, Multiple Sclerosis, Paraplegic, Quadriplegia and Hemoplegia, Respiratory failure on a ventilator.

- Expected LOS greater than 48 hours
- Complexity of care: More than three (3) physicians involved
- New dialysis
- Scarce finances or inadequate insurance coverage for anticipated needs
- Repeat admission (within 30 days)
- Behavioral problems
- Non-compliance
- Lack of support systems/unclear decision-maker status
- Anyone over 80 years of age or between the ages of 75-80 and living alone
- Admitted from nursing home or assisted living facility
- Any suspicion of abuse/neglect
- Homeless

I. RESPONSIBILITIES:

A. ATTENDING/ADMITTING PHYSICIAN

The attending/admitting physician shall:

1. Assess and identify discharge planning needs of his/her patients and order appropriate consults to address these needs in a timely manner.

2. Collaborates with the patient, family, and members of the health-care team to determine and implement an appropriate safe discharge plan and to complete necessary paperwork to refer his/her patient to outside agencies and facilities.

3. Determine when the patient is ready for discharge and orders the discharge.

4. Document the discharge needs and follow-up plan of care in the patient's medical record.

B. NURSING

1. The nurse will assess the patient's physical, social, and psychological condition upon admission to the unit, recording the data on the admission assessment form. This assessment will also include the current self-care needs of the patient as well as needs that may exist at discharge. The initial discharge plan will be based on this assessment which includes:

   a. Current health status
   b. Projected level of care needed upon discharge
   c. Teaching necessary prior to discharge
   d. Patient strengths and weaknesses
   e. Resources available for post-hospital care
   f. Ability of the patient/significant other/care giver to arrange continuing care needs

2. Make referrals to appropriate disciplines for further assessment. Patients determined to require intensive planning will be reviewed and/or discussed at regularly scheduled interdisciplinary care discharge planning meetings and the discharge plan will be reassessed and modified as appropriate.

3. The charge nurse will lead the unit specific interdisciplinary care planning meetings, assure that meetings start and end on time and remain focused on the patients with discharge planning needs. He/she will initiate and document updates on the Interdisciplinary Plan of Care for those patients requiring intensive planning.

4. Initiate the patient discharge process as ordered by the physician.

   a. Attending physician, or his/her designee, must issue or approve an order for patient discharge.
   b. If a consulting physician writes an order to initiate patient discharge, the nurse contacts the attending physician (or designee) and obtains approval for the discharge.
   c. The attending physician's order for discharge must be recorded on the Physician's Order Form.
   d. If a nurse identifies a barrier involving the implementation of a safe discharge plan, He/she should contact the physician (attending) for reassessment of patient's condition, readiness for discharge or discharge plan, and or specificity of the discharge plan.

C. REHABILITATION MEDICINE

1. All patients undergo screening for functional assessment.

2. Rehabilitation Medicine Therapist will attend the interdisciplinary care planning meetings as needed.

3. Discharge instructions given to the patient/care giver as well as equipment issued by the therapist and instructions for its use will be documented in their daily charting.

D. BEHAVIORAL HEALTH (2100)

The Social Worker (SW) will:

1. Assess the needs of all patients admitted to Behavioral Health. This evaluation will begin with review of the Multidisciplinary Assessment for Behavioral Medicine completed by the Needs Assessment Clinician prior to admission. If this document is not complete due to the patient's mental status upon admission or if the patient was a transfer from another hospital, the social worker will fill in missing information. Patients should be seen within thirty-six hours of admission.

2. Review the nursing data base to determine how the patient's physical health impacts his cognitive/emotional state and how both conditions will affect discharge planning. Once done, completes the Initial Social Work Note to add to the Medical Record.

3. Review the legal status of the patient. If the patient is involuntary, determine the validity of the certificates and accompanying paperwork. If a voluntary has been signed, subsequent to admission, determine if the physician has endorsed this document. If the patient remains on involuntary status, prepare to present the case at hearing when appropriate.

4. Collaborate with the psychiatrist and the multidisciplinary treatment team on the status of the patient, the estimated length of stay, the provisional discharge plan and potential barriers to discharge. Particular focus will be given to patients with the following conditions/needs and will be addressed, along with the more routine discharge considerations, in the medical record as appropriate

1. Placement in group home or nursing care facility
2. Homelessness
3. Possible need for guardianship or determination of competence
4. Frequent admissions/readmissions to Behavioral Health
5. History of non compliance with medication and outpatient treatment
6. Serious medical conditions
7. History of multiple suicide attempts
8. History of aggression towards others
9. Patients who have a history of abuse and/or neglect

5. Conduct an in depth interview with the patient if there is a co-occurring disorder, e.g. substance abuse and record the information on the "Supplemental Substance Abuse Questionnaire".

6. Interview the patient to determine if he/she has outpatient providers; is connected with community agencies; utilizes these supports and is compliant with treatment.

7. Obtain collateral information from family members, outpatient providers, relevant community agencies. Particularly important for the discharge process is to ascertain and document baseline functioning and to involve those in the patient's support system.

8. When placement, guardianship, or referral to agencies such as Protective Services is indicated, immediately initiate the actions which will ensure the safety and well being of the patient.

9. At time of discharge review with the psychiatrist the discharge plan to determine if it continues to be realistic, safe and appropriate for the patient's needs or needs to be modified. The reassessment of the discharge plan will be documented in the medical record.

E. CASE MANAGEMENT

The Social Worker (SW) or RN Case Managers (CM) will:

1. Assess the needs of those patients on his/her unit utilizing, but not limited to, the Intervention Parameters list and the admission assessment screen. Referrals to case management may come from any source including, but not limited to: physician, nursing staff, patient, family, external agency.

2. Further assess patients who trigger a screen through the nursing assessment process, as defined above and initiate discharge planning on those patients identified as meeting any of the intervention parameters within two (2) working days. A social worker and/or nurse case manager is available to initiate a safe discharge for those patients identified for weekend discharge.

3. Contact the attending physician to coordinate plans and to keep him/her informed of progress and changes.

4. Review the patient chart and interview the patient/care giver to gather pertinent information about resources, previous level of care, and ability to engage in discharge planning.

5. Coordinates the interdisciplinary care planning process through discharge, including:

- Availability of services to meet the patient's identified needs at discharge, including education about options and patient/family (SO) agreement with plan and final discharge plan in the patient's medical record.
- Tracking patient progress to discharge, identifying potential obstacles and team member responsibilities for follow through. If barriers are identified which prevent the patient from following the recommendation for a safe discharge, a reassessment will be completed.
- Appropriate internal and external referrals, including arrangements for Home Health, DMEs, home IVs or oxygen.
- Referring patients to ancillary services and community resources as appropriate.
- Facilitate discharge to continuum of care facility.

6. Participate in the unit specific interdisciplinary care planning meetings.

7. Case management will document pertinent assessment information (Assessment Form) and continuing interventions (Patient Progress Notes).

8. Performing case management functions on a case-by-case basis to assure continuity of care and identify barriers through reassessment of patients needs.

F. NUTRITIONAL SERVICES

1. Patients will be screened upon admission to the hospital for a length of stay of greater than 24 hours to identify nutritional problems and to evaluate the need for further nutritional intervention.
2. Referrals will be sent for the dieticians to conduct nutritional assessments. A follow-up screening and assessment will be performed by Nutrition Services, as appropriate.
3. Prior to discharge, any patient needing nutrition education will receive instructions, which is documented on the Patient Progress note.
4. Attendance at the interdisciplinary care planning meetings will be determined by the dietician covering the individual unit in consultation with the other interdisciplinary team members.

G. PASTORAL CARE

1. A chaplain or student intern will attend the interdisciplinary care planning meetings whenever possible.
2. Emergency needs will be seen to as soon as possible.
3. Requests for services may be made by any discipline by calling Pastoral Care.
4. Interventions are documented on the Patient Progress note.

H. RESPIRATORY CARE

1. Education required by the patient/care giver in the use of equipment and/or home treatments will be provided by the respiratory care practitioner prior to discharge and documented in their daily charting.

2. Attendance at the interdisciplinary care planning meetings will be on an as needed basis.

I. PHARMACY

1. Instruction concerning medications will be provided by the RN with additional support from the pharmacist when needed. Patient/care giver instruction will be documented on the discharge record.

2. The pharmacist will attend interdisciplinary care planning meetings as needed.

J. SOCIAL WORKER

1. The Social Worker initiates psychosocial assessment for all identified and referred patients.

2. The Social Worker counsels patient and family for emotional adjustment to illness and safe discharge plan.

K. PATIENT, PATIENT'S FAMILY, GUARDIAN

The patient, if competent, makes the ultimate decision regarding the final discharge plan after taking into account the recommendation of the physician and other members of the health-care team and involved family members. He/she needs to participate in learning about discharge planning needs and available options, weigh the risks and benefits of these options and communicate his/her decision to the health-care team. If the patient is judged incompetent by a court of law or by two physicians who certify that the patient is disabled ("lacks sufficient understanding or capacity to make or communicate a responsible decision on health care"), or if the patient is a minor, the decision-making responsibility falls to the patient's guardian, legally-authorized representative or next-of-kin as detailed by Maryland State Law. (See Policy WAH.5852).

II. INTERDISCIPLINARY CARE PLANNING MEETINGS

A. Interdisciplinary Care Planning meetings are held daily (Monday – Friday) on all in-patient nursing units to facilitate inter-disciplinary collaboration for discharge planning. Meetings are attended by Nursing and Case Management staff (case manager and/or Social Work) to review all patients on the unit, to identify patients who have discharge planning needs, to track care planning progress, and to facilitate meeting identified needs. Other members of the care team may attend the meetings on an "as needed" basis. Included in the discussion will be patient's diagnosis, overall plan of care, reason for continued acute admission, plan for the day, anticipated discharge date, and anticipated discharge needs. While all patients are reviewed for discharge planning needs, there is focused effort on those patients requiring intensive planning.

B. Interdisciplinary Treatment Team meetings are held daily on the Behavioral Health Unit. They are attended by Psychiatrists, Nursing, Social Work, Utilization Management and Out-patient services. Other members of the health care team attend as needed. The goals and objectives listed above areas the same as stated above for the Medical units.

Attachment 11

Audited financial statements

Adventist HealthCare, Inc.

Consolidated Financial Statements
For The Years Ended
December 31, 2008 and 2007
& Independent Auditors' Report
& Additional Information

Table of Contents

PARENTERANDOLPH

The Power of Ideas

Independent Auditors' Report

Board of Trustees
Adventist HealthCare, Inc.

We have audited the accompanying consolidated balance sheets of Adventist HealthCare, Inc. and controlled entities (the "Corporation") as of December 31, 2008 and 2007, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adventist HealthCare, Inc. and controlled entities as of December 31, 2008 and 2007, and the results of their operations, changes in net assets, and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

As disclosed in Note 2 to the consolidated financial statements, the Corporation adopted the provisions of Statement of Financial Accounting Standards Nos. 157 and 159 in 2008.

Parente Randolph, LLC

Wilkes-Barre, Pennsylvania
May 13, 2009

Adventist HealthCare, Inc.
Consolidated Balance Sheets
December 31, 2008 and 2007

	2008	2007
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 15,671,658	$ 11,893,028
Short-term investments	139,716,446	150,853,703
Assets whose use is limited	8,820,090	8,853,524
Patient accounts receivable, net of estimated allowances of $64,588,000 in 2008 and $54,249,000 in 2007	115,357,553	108,693,258
Other receivables, net of estimated allowance for uncollectible accounts of $1,286,000 in 2008 and $1,450,000 in 2007	9,633,899	11,570,622
Inventories	10,800,753	10,847,799
Prepaid expenses and other current assets	3,548,970	3,947,675
TOTAL CURRENT ASSETS	**303,549,369**	**306,659,609**
PROPERTY AND EQUIPMENT, Net	385,618,363	373,421,840
ASSETS WHOSE USE IS LIMITED:		
Under trust indentures, held by trustees	18,196,283	12,455,223
Professional liability trust fund	6,188,516	11,592,512
Deferred compensation fund	1,241,374	3,978,908
CASH AND CASH EQUIVALENTS TEMPORARILY RESTRICTED FOR CAPITAL ACQUISITION	2,456,183	1,279,886
INVESTMENTS AND INVESTMENTS IN UNCONSOLIDATED SUBSIDIARIES	11,559,207	11,066,870
LAND HELD FOR HEALTHCARE DEVELOPMENT	55,813,484	47,323,506
DEFERRED FINANCING COSTS, Net	4,397,100	4,573,968
INTANGIBLE ASSETS, Net	7,968,423	8,403,860
DEPOSITS AND OTHER NONCURRENT ASSETS	9,113,310	11,439,474
TOTAL	$ 806,101,612	$ 792,195,656

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.
Consolidated Balance Sheets
December 31, 2008 and 2007

	2008	2007
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 66,089,839	$ 69,171,238
Accrued compensation and related items	33,046,052	28,483,950
Interest payable	1,266,196	1,589,984
Due to third party payors	16,581,868	13,782,996
Estimated self-insured professional liability	1,185,808	1,411,795
Short-term financing	20,000,000	-
Current maturities of long-term obligations	81,075,497	15,159,177
TOTAL CURRENT LIABILITIES	**219,245,260**	**129,599,140**
CONSTRUCTION PAYABLE	1,429,678	10,236,918
LONG-TERM OBLIGATIONS, Net:		
Bonds payable	196,903,411	268,908,628
Notes payable	89,619,959	65,100,626
Capital lease obligations	22,231,317	20,964,945
DERIVATIVE FINANCIAL INSTRUMENTS	23,206,843	4,511,329
DEFERRED COMPENSATION	1,241,484	3,978,970
OTHER LIABILITIES	5,708,439	5,195,569
ESTIMATED SELF-INSURED PROFESSIONAL LIABILITY	7,146,732	9,916,023
TOTAL LIABILITIES	**566,733,123**	**518,412,148**
NET ASSETS:		
Unrestricted	229,318,759	263,751,592
Temporarily restricted	9,715,879	9,925,378
Permanently restricted	333,851	106,538
TOTAL NET ASSETS	239,368,489	273,783,508
TOTAL	**$ 806,101,612**	**$ 792,195,656**

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.
Consolidated Statements of Operations
For the Years Ended December 31, 2008 and 2007

	2008	2007
UNRESTRICTED REVENUES:		
Net patient service revenue	$ 774,014,846	$ 725,764,577
Other revenue	40,425,837	40,894,345
TOTAL UNRESTRICTED REVENUES	814,440,683	766,658,922
EXPENSES:		
Salaries and wages	334,836,121	313,528,051
Employee benefits	65,229,075	61,561,643
Contract labor	32,400,235	33,733,108
Medical supplies	119,372,823	117,269,272
General and administrative	114,109,674	106,938,299
Building and maintenance	42,250,054	39,932,983
Insurance	2,021,391	5,605,356
Provision for uncollectible accounts	43,302,605	41,368,588
Interest	14,526,306	13,801,594
Depreciation and amortization	33,655,370	30,870,173
Loss on impairment of long-lived assets	-	1,072,347
TOTAL EXPENSES	801,703,654	765,681,414
INCOME FROM OPERATIONS	12,737,029	977,508
OTHER INCOME (EXPENSE):		
Investment (loss) income	(21,052,090)	10,377,621
Other income	746,108	14,535,438
TOTAL OTHER (EXPENSE) INCOME	(20,305,982)	24,913,059
PORTION OF EARNINGS RELATED TO MINORITY INTEREST	(124,523)	(3,769,034)
REVENUES (LESS THAN) IN EXCESS OF EXPENSES	(7,693,476)	22,121,533
Change in net unrealized gains and losses on investments other than trading securities	(11,489,990)	5,047,791
Change in unrealized loss on derivative financial instruments	(17,552,352)	(4,104,863)
Transfer to unconsolidated subsidiary	(19,260)	8,821
Net assets released from restriction for purchase of property and equipment	2,325,529	3,642,675
Change in minority interest	(16,459)	125,309
Other unrestricted net asset activity	13,175	(508,630)
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	$ (34,432,833)	$ 26,332,636

Adventist HealthCare, Inc.

Consolidated Statements of Changes in Net Assets

For The Years Ended December 31, 2008 and 2007

	2008	2007
UNRESTRICTED NET ASSETS:		
Revenues (less than) in excess of expenses	$ (7,693,476)	$ 22,121,533
Change in net unrealized gains and losses on investments other than trading securities	(11,489,990)	5,047,791
Change in unrealized loss on derivative financial instruments	(17,552,352)	(4,104,863)
Transfer to unconsolidated subsidiary	(19,260)	8,821
Net assets released from restriction for purchase of property and equipment	2,325,529	3,642,675
Change in minority interest	(16,459)	125,309
Other unrestricted net asset activity	13,175	(508,630)
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	(34,432,833)	26,332,636
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted gifts and donations	6,640,938	3,690,771
Net assets released from restriction for purchase of property and equipment	(2,325,529)	(3,642,675)
Net assets released from restriction used for operations	(3,173,025)	(770,364)
Change in value of beneficial interest in trusts and charitable gift annuity obligation	(349,380)	13,110
Change in discount of pledges receivable and provision for doubtful pledges	(982,622)	128,067
Donor restricted investment (loss) income	(19,881)	227
Other temporarily restricted net asset activity	-	(76,367)
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	(209,499)	(657,231)
PERMANENTLY RESTRICTED NET ASSETS,		
Other permanently restricted net asset activity	227,313	106,538
(DECREASE) INCREASE IN NET ASSETS	(34,415,019)	25,781,943
NET ASSETS, BEGINNING	273,783,508	248,001,565
NET ASSETS, ENDING	$ 239,368,489	$ 273,783,508

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.
Consolidated Statements of Cash Flows
For The Years Ended December 31, 2008 and 2007

	2008	2007
CASH FLOWS FROM OPERATING ACTIVITIES		
(Decrease) increase in net assets	$ (34,415,019)	$ 25,781,943
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities		
Provision for uncollectible accounts	43,302,605	41,368,588
Depreciation and amortization	33,655,370	30,870,173
Loss on impairment of long lived assets	-	1,072,347
Gain on sale of property and equipment	(5,097)	(10,407,304)
Restricted contributions and grants	(6,245,841)	(5,664,344)
Reclassification of minority interest	-	(1,800,590)
Change in minority interest	-	412,186
Distribution to minority interest shareholders	-	1,565,000
Earnings recognized from unconsolidated subsidiaries and affiliates	(3,593,807)	(2,386,153)
Amortization of bond discounts	9,790	9,790
Amortization of physician income guarantees	481,508	621,991
Other net asset activity	-	573,743
Change in unrealized gains and losses on investments other than trading securities	11,592,402	(5,047,791)
Change in net unrealized loss on derivative financial instruments	18,695,514	2,653,516
Change in fair value of charitable remainder trusts and obligations to annuitants	349,380	(208,482)
Change in discount on pledges receivable and provision for doubtful pledges	(104,895)	(128,067)
Changes in assets and liabilities:		
Patient accounts receivable, net	(49,815,270)	(42,500,159)
Other receivables, net	1,822,548	3,804,213
Inventories, prepaid expenses and other current assets	(565,105)	53,194
Accounts payable and accrued expenses	(2,754,691)	(1,170,419)
Accrued compensation and related items	4,746,933	2,643,233
Interest payable	(323,788)	(67,167)
Estimated self-insured professional liability	2,634,705	(1,109,710)
Due to third party payors	2,798,872	(2,929,881)
Other noncurrent assets and liabilities	865,055	(3,782,927)
NET CASH PROVIDED BY OPERATING ACTIVITIES	23,131,169	34,226,923

(Continued)

Adventist HealthCare, Inc.
Consolidated Statements of Cash Flows - Continued
For The Years Ended December 31, 2008 and 2007

	2008	2007
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property and equipment	$ (51,955,097)	$ (58,133,106)
Payments to physicians under income guarantees	(100,228)	(644,298)
Increase in investments and investments in unconsolidated subsidiaries	(2,218,620)	(7,835,533)
Net additions to land held for healthcare development	(8,489,978)	(4,794,631)
Proceeds from the sale of property and equipment	5,097	15,498,855
Distributions from investments in unconsolidated subsidiaries	5,055,768	(1,163,080)
(Increase) decrease in trustee held funds/restricted cash	(7,460,217)	11,154,231
NET CASH USED IN INVESTING ACTIVITIES	(65,163,275)	(45,917,562)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments of financing costs	(122,122)	(196,237)
Repayments on long-term obligations, net	(15,487,983)	(10,550,898)
Proceeds from issuance of long-term obligations, net	35,175,000	6,611,407
Proceeds from short-term financing	20,000,000	5,050,000
Distribution of minority interest holders	-	(1,565,000)
Transfers in connection with sale of investments	-	(49,471)
Proceeds from restricted contributions and grants	6,245,841	5,664,344
NET CASH PROVIDED BY FINANCING ACTIVITIES	45,810,736	4,964,145
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	3,778,630	(6,726,494)
CASH AND CASH EQUIVALENTS, BEGINNING	11,893,028	18,619,522
CASH AND CASH EQUIVALENTS, ENDING	$ 15,671,658	$ 11,893,028
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Interest paid	$ 12,989,980	$ 11,973,747
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITIES		
Capital lease obligation incurred for equipment	$ 1,961,966	$ 6,609,784
Construction payable for property and equipment	$ 1,429,678	$ 13,823,900

See Notes to Consolidated Financial Statements

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Adventist HealthCare, Inc. (AHC) is a nonstock membership corporation organized to effectuate coordinated administration of hospitals and other health care organizations through the provision of key management and administrative services. AHC is tax-exempt under Section 501(c) (3) of the Internal Revenue Code. AHC is not exempt from income taxes for unrelated business income. AHC's sole corporate member is Mid-Atlantic Adventist HealthCare, Inc. (MAAHC).

AHC is comprised of several operating divisions. Shady Grove Adventist Hospital (SGAH) is a 293-bed acute care hospital located in Rockville, Maryland. Washington Adventist Hospital (WAH) is a 292-bed acute care hospital with 22 acute rehabilitation beds located in Takoma Park, Maryland. Potomac Ridge Behavioral Health (Potomac Ridge) is comprised of three separate facilities located in Maryland. Potomac Ridge Behavioral Health at Rockville is a 97-bed psychiatric hospital with 82 residential treatment rooms. Potomac Ridge Behavioral Health at Eastern Shore is the region's only acute care and residential mental health resource for children and adolescents, which has 15 acute care psychiatric beds and 59 residential treatment rooms. Potomac Ridge Behavioral Health at Anne Arundel offers 28 adolescent residential treatment beds, 18 group home beds for adolescent males, and 65 slots for special and general education for adolescents with emotional and behavioral disabilities. The Support Center is comprised of the corporate office that provides corporate and centralized shared service functions that benefit the entire healthcare system. The Support Center is comprised of the following units: Adventist Preferred Nursing (APN), Adventist Choice Nursing (ACN), Adventist Home Assistance (AHA) and the AHC Benefit business unit. APN maintains and manages a pool of skilled nurses that provide services to affiliated healthcare entities for a fee. ACN provides skilled nursing care to individual patients and other healthcare entities not affiliated with AHC. AHA provides non-clinical assistance to homebound patients who cannot perform certain daily activities on their own. The AHC Benefit business unit administers the self insured health benefit program including health insurance, dental and vision coverage for Adventist HealthCare, Inc. and controlled entities.

Hackettstown Community Hospital d.b.a. Hackettstown Regional Medical Center (HRMC) is a 111-bed not-for-profit acute care hospital organized under the laws of the State of New Jersey. The primary purpose of HRMC is to participate in the health ministry of the Seventh-day Adventist Church and to promote the wholeness of man physically, mentally and spiritually through acute care hospital services. HRMC is tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Adventist Rehabilitation Hospital of Maryland, Inc. (ARHM) is a 55-bed rehabilitation facility with outpatient services sites in Montgomery County, Maryland. ARHM is tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

The Reginald S. Lourie Center for Infants and Young Children (Lourie Center) is a not-for-profit organization that specializes in the diagnosis, treatment and prevention of developmental and emotional disorders in children from birth through ten years of age. The Lourie Center is tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Adventist Physician Services, Inc. (APS) is a not-for-profit entity that provides physician professional health services to further provide necessary services to the communities it serves.

Adventist Senior Living Services, Inc. (ASLS) is a nonstock membership corporation that provides management and support services to five subsidiary nursing homes, a wholly-owned dialysis center, and one affiliated nursing home. The facilities' residents primarily come from the State of Maryland. ASLS and its subsidiary nursing homes are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Adventist Home Health Services, Inc. (AHHS) is a nonstock membership corporation organized to provide home health services in Maryland. It is tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Adventist Management Services, Inc. (AMSI) is organized as a taxable corporation to provide management services to its subsidiaries that provide various health care services including, but not limited to a wholly-owned healthcare recruitment organization, GROW HealthCare, LLC.

Adventist Cardiac Services, Inc. (ACS) has been established to administer global contracts with third-party payers for the provision of cardiac care to patients who receive certain services at WAH. The global contracts administered by ACS were terminated in September 2006. Articles of dissolution were filed with the State of Maryland Department of Assessments and Taxation in November 2007.

Washington Adventist Hospital Foundation, Inc. (WAH Foundation), Shady Grove Adventist Hospital Foundation, Inc. (SGAH Foundation), Hackettstown Community Hospital Foundation, Inc. (HCH Foundation), and Potomac Ridge Behavioral Health Foundation (Potomac Ridge Foundation) (collectively the "Foundations") are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals.

Principles of Consolidation

The consolidated financial statements for 2008 and 2007 include the accounts of AHC, the controlling parent, HRMC, ARHM, the Lourie Center, APS, ASLS, AHHS, AMSI, ACS, the Foundations, and their majority-owned subsidiaries and controlled affiliates (collectively the "Corporation"). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Risk Factors

The Corporation's ability to maintain and/or increase future revenues could be adversely affected by: (1) proposed and/or future changes in the laws, rules, regulations, and policies relating to the definition, activities, and/or taxation of not-for-profit tax-exempt entities; (2) the enactment into law of all or any part of the current budget resolutions under consideration by Congress related to Medicare and Medicaid reimbursement methodology and/or further reductions in payments to hospitals and other health care providers; (3) the limited supply of physicians and healthcare professionals nationally which may limit the Corporation's ability to meet the healthcare demands of the population within its primary and secondary service areas; and (4) the future of Maryland and New Jersey's Certificate of Need (CON) programs, where future deregulation could result in the entrance of new competitors, or future additional regulation may eliminate the Corporation's ability to expand new services.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a non-governmental privately owned entity, provides accreditation status to hospitals and other health care organizations in the United States of America. Such accreditation is based upon a number of requirements such as undergoing periodic surveys conducted by JCAHO personnel. Certain managed care payers require hospitals to have appropriate JCAHO accreditation in order to participate in those programs. In addition, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMS), the agency with oversight of the Medicare and Medicaid programs, provides "deemed status" for facilities having JCAHO accreditation. By being JCAHO accredited, facilities are "deemed" to be in compliance with the Medicare and Medicaid conditions of participation. Termination as a Medicare provider or exclusion from any or all of these programs/payers would have a materially negative impact on the future financial position, operating results and cash flows of the Corporation. SGAH, WAH, HRMC, Potomac Ridge, and ARHM have received full accreditation for 2008 and 2007.

Maryland Health Services Cost Review Commission

Patient charges of SGAH, WAH, Potomac Ridge and ARHM (Hospitals) are subject to review and approval by the Maryland Health Services Cost Review Commission (HSCRC). Management has filed the required reports with the HSCRC for each facility and believes they are in compliance with the HSCRC requirements.

The HSCRC has placed into its methodology a rate system which, among other things, causes SGAH, WAH, and Potomac Ridge to calculate the amount of revenue lost or gained due to variances from approved rates (price variances). Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates.

Effective July 1, 2000, SGAH and WAH entered into agreements with the HSCRC to participate in a new methodology regarding inpatient rates. This new Charge per Case (CPC) methodology rewards hospitals for reducing utilization per case (case mix adjusted) and penalizes hospitals for increasing utilization per case (case mix adjusted). Variances between actual revenue and allowed CPC revenue are adjusted in a manner similar to that described above. Adjustments caused by these variances are applied by the HSCRC prospectively in connection with the calculation of the annual inflation adjustment and, accordingly, impact a year subsequent to the year in which such variances occur. The Corporation's consolidated financial statements reflect current year undercharges and/or overcharges for inpatient services as a component of net patient service revenue in the year such variances occurred. Undercharges and overcharges related to outpatient services are handled and reported in a similar manner.

The Corporation reported net overcharges of $1,023,956 and $1,484,926 as of December 31, 2008 and 2007, respectively. These overcharges reflect (1) the variance between actual patient charges and the Hospital's respective rate orders, and (2) a provision for expected rate adjustments related to the case mix experience of WAH and SGAH. Overcharges are reported as a reduction to net patient service revenue and the patient accounts receivable balance. Since the HSCRC's rate year extends from July 1 through June 30, these overcharges will continue to fluctuate until the end of the rate year, at which time any over/under charges are amortized on the straight-line basis over the following rate year, and are reflected as a component of net patient service revenue.

Under Maryland law, charges of ARHM are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from HSCRC's requirements to charge for services in accordance with HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and the level of total revenue must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue if an exemption regarding charging for services is received. The Corporation's management believes ARHM met the conditions for exemption for 2008 and 2007.

Cash and Cash Equivalents

Cash and cash equivalents include investments in money market funds and certificates of deposit purchased with original maturities of less than 90 days, excluding assets whose use is limited.

Patient Accounts Receivable

Patient accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. The allowance for uncollectible accounts is estimated based upon a periodic review of the accounts receivable aging, payor classifications and application of historical write-off percentages.

Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors. These services include but are not limited to fees from educational programs, rental of health care facility space, interest earned, and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts. The allowance for doubtful accounts is estimated based upon historical collection experience and other managerial information.

Assets Whose Use Is Limited

Assets whose use is limited includes assets held by bond trustees under trust indentures, assets set aside as required by the Corporation's self-funded professional liability trust, and deferred compensation agreements. Amounts available to meet current liabilities of the Corporation have been reclassified as current assets in the accompanying consolidated balance sheets.

Investments and Investment Risk

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Cash and cash equivalents and certificates of deposit are carried at cost which approximates fair value. Investment income or loss (including realized gains and losses on investments, write-downs of the cost basis of investments due to an other-than-temporary decline in fair value, interest, and dividends) is included in the determination of revenues (less than) in excess of expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the determination of revenues (less than) in excess of expenses unless the investments are trading securities. Donor-restricted investment income is reported as an increase in temporarily restricted net assets.

The Corporation's investments are comprised of a variety of financial instruments. The fair values reported in the consolidated balance sheets are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the accompanying consolidated financial statements could change materially in the near term.

Inventories

Inventories of drugs and medical and surgical supplies are valued at the lower of cost or market. Cost is determined primarily by the weighted average cost method.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets (which ranges from 3 to 40 years) using the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated statements of operations.

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2008 and 2007, SGAH, WAH and HRMC capitalized interest in conjunction with construction projects. Interest incurred by these three entities (exclusive of letter of credit and remarketing fees) was approximately $9,866,000 in 2008 and $11,402,000 in 2007, of which approximately $2,395,000 was capitalized in 2008 and $3,516,000 in 2007. Investment earnings of approximately $307,000 in 2008 and $442,000 in 2007 were offset against the capitalized interest. ASLS incurred interest costs related to borrowed funds for construction on certain facilities. The total incurred by these facilities related to borrowed funds for construction in 2008 was approximately $834,000, of which $126,000 was capitalized, net of investment earnings of approximately $22,000. In addition, the Corporation capitalizes all of the interest incurred on the $20,000,000 line of credit that has funded the acquisition of land held for healthcare development (*Note 8*). Capitalized interest related to this line of credit was approximately $783,000 in 2008 and $1,143,000 in 2007.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There was no impairment loss reported in 2008, however the Corporation recognized an impairment loss of $1,072,347 in 2007 *(Note 6)*.

Intangible Assets

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing the goodwill that has been recognized related to certain business acquisitions over a period not to exceed 40 years. Amortization of goodwill and other intangible assets was $ 370,766 in 2008 and $264,917 in 2007. Accumulated amortization of goodwill and other intangible assets was $1,017,044 in 2008 and $646,278 in 2007.

Deferred Financing Costs

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Amortization was $298,991 in 2008 and $308,878 in 2007. Accumulated amortization of deferred financing costs was $1,886,961 in 2008 and $1,587,970 in 2007.

Due to Third Party Payers

The Corporation receives advances from third party payers to provide working capital for services rendered to the beneficiaries of such services. These advances are subject to periodic adjustment, and are principally determined based on the timing difference between the provision of care and the anticipated payment date of the claim for service in accordance with HSCRC's rate regulations.

For HRMC, the Medicare and Medicaid programs pay for primarily all inpatient and outpatient services at predetermined rates. Regulations require annual retroactive settlements for cost-based reimbursement through cost reports filed by HRMC. These retroactive settlements are estimated and recorded in the financial statements in the year in which they occur. The estimated settlements recorded at December 31, 2008 and 2007 could differ from actual settlements based on the results of cost report audits.

For certain Corporation subsidiaries, services provided on behalf of Medicare and Medicaid beneficiaries are ultimately reimbursed at cost. For cost reimbursement programs, statements of reimbursable costs are filed with the applicable program that compute the difference between reimbursable cost and interim payments, in order to determine a final settlement for services rendered to patients covered under these programs. Contractual reimbursements are affected by limitations relating to charges and the reasonableness of costs (subject to limitations) and are subject to audits by the agencies administering the applicable program.

The Corporation's working capital advances and all expected third party settlement activity are classified as current liabilities in the accompanying consolidated balance sheets.

Derivative Financial Instruments

The Corporation entered into four interest rate swap agreements, which are considered derivative financial instruments, to manage its interest rate exposure on certain long-term obligations. Management has designated two of the interest rate swap agreements as cash flow hedges. The interest rate swap agreements are reported at fair value in the accompanying consolidated balance sheets. For the cash flow hedges, the related effective changes in fair value are reported in the accompanying consolidated statements of operations as an unrealized gain or loss on cash flow derivative financial instrument and the ineffective portion of the change in fair value is reported as a component of interest expense. For the interest rate swaps not designated as cash flow hedges, changes in fair value are reported as a component of other non-operating income.

Estimated Medical Malpractice Costs

The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets whose use by the Corporation has been limited by donors to a specific time period or purpose are available for the purchase of capital renovations and equipment, providing health education to the community, and designated for the furtherance of programs provided by specific operating departments. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Revenues (Less Than) in Excess of Expenses

The consolidated statements of operations include the determination of revenues (less than) in excess of expenses. Changes in unrestricted net assets which are excluded from the determination of revenues (less than) in excess of expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, the effective portion of the unrealized gain (loss) on cash flow derivative financial instruments, other unrestricted net asset activity, transfers with unconsolidated subsidiaries, changes in minority interest, and contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets).

Net Patient Service Revenue

The Corporation reports net patient service revenue at the estimated net realizable amounts from patients, third party payers, and others for services rendered, including an estimate for retroactive adjustments that may occur as a result of future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, review and investigations. Allowances for the excess of charges over anticipated patient or third party payer payments are included in the determination of net patient service revenue as reported in the consolidated statements of operations, whereas net uncollectible self-pay amounts are reported as an operating expense. Certain of the health care services provided by the Corporation are reimbursed by third party payers on the basis of the lower of cost or charges, with costs subject to certain imposed limitations.

Patient accounts receivable are reported at net realizable value and include charges for accounts due from Medicare, Medicaid, CareFirst, other commercial and managed care insurers, and self-paying patients (*Note 16*). Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed above. Deducted from patient accounts receivable are estimates of uncollectible accounts related to patients, and allowances for the excess of charges over the payments to be received from third party payers.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation for which action for noncompliance can include fines, penalties, and exclusion from the Medicare and Medicaid programs. The Corporation is not aware of any pending or threatened investigations involving allegations of potential wrongdoing which could have a material adverse effect on the accompanying consolidated financial statements.

Income Taxes

The Corporation follows the guidance in FASB Staff Position FAS 126-1, "Applicability of Certain Disclosure and Interim Reporting Requirements for Obligors for Conduit Debt Securities" ("FSP 126-1"). FSP 126-1 amended certain accounting literature to include conduit debt obligors in the definition of a public entity or enterprise. As a result, the Corporation adopted FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes – an interpretation of FASB Statement No. 109" income taxes recognized in a company's financial statements and prescribes a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold has been met. FIN 48 also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, and disclosure. Management has determined that the adoption of FIN 48 did not have a material effect on the financial effect on the consolidated financial statements.

The Corporation's policy is to recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses. There were no interest or penalties recognized in the consolidated statement of operations as a result of adopting FIN 48.

The Corporation's federal Exempt Organization Business Income Tax Returns for 2005, 2006, and 2007 remain subject to examination by the Internal Revenue Service.

Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Such patients are identified based on financial information obtained from the patient (or their guarantor) and subsequent analysis which includes the patient's ability to pay for services rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as a component of net patient service revenue or patient accounts receivable.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statement of operations as net assets released from restrictions. Funds that are restricted to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of unrestricted net assets.

Investment income that is earned on donor restricted net assets and subject to similar restrictions is reported as temporarily restricted net assets. Gifts, grants and bequests not restricted by donors are reported as other operating income.

Advertising Costs

The Corporation expenses advertising costs as they are incurred. Advertising expense was approximately $ 2,899,000 in 2008 and $2,703,000 in 2007.

Reclassifications

Certain amounts relating to 2007 have been reclassified to conform to the 2008 reporting format.

2. ADOPTION OF ACCOUNTING PRONOUNCEMENTS

SFAS No. 157

Effective January 1, 2008, the Corporation adopted Statement of Financial Accounting Standards ("SFAS") No. 157, "Fair Value Measurements." SFAS No. 157 defines fair value, establishes a framework for measuring fair value under accounting principles generally accepted in the United States of America, and enhances disclosures about fair value measurements. Fair value is defined as the price that would be received to sell an asset or the price that would be paid to dispose of a liability in an orderly transaction between market participants at the measurement date. The framework that SFAS No. 157 establishes for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement. The levels of the fair value hierarchy are as follows:

Level 1 – Fair value is based on unadjusted quoted prices in active markets that are accessible to the Corporation for identical assets. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 – Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the full term of the asset through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 – Fair value would be based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

SFAS No. 159

Effective January 1, 2008, the Corporation adopted SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities" ("SFAS No. 159"). SFAS No. 159 permits entities to make an irrevocable election to value certain financial assets and liabilities, on an instrument-by-instrument basis, at fair value and include the change in fair value within the performance indicator. The Corporation did not elect the fair value option for eligible items.

Adoption of SFAS No. 159 had no effect on the change in unrestricted net assets or the carrying value of the Corporation's consolidated financial instrument.

3. Charity Care

The Corporation maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the level of charity care provided during the years ended December 31:

	2008	2007
Charges foregone, based on established rates	$25,708,553	$26,005,383

The State of New Jersey created the Health Care Subsidy Fund (HCSF) for various purposes including the distribution of charity care payments to hospitals statewide. Subsidy amounts of $348,228 in 2008 and $498,146 in 2007 are included in net patient service revenue.

4. Investments

Short-Term Investments

The Corporation's short-term investments at December 31, 2008 and 2007 are comprised of the following:

	2008	2007
Cash and cash equivalents and certificates of deposit	$ 29,659,585	$ 5,891,633
Equities	23,153,843	40,146,879
Mutual funds	86,903,018	104,815,191
	$139,716,446	$150,853,703

Assets Whose Use Is Limited

The composition of assets whose use is limited at December 31, 2008 and 2007 is set forth in the following table:

	2008	2007
Under trust indentures, held by trustees:		
Cash and cash equivalents	$ 10,314,057	$ 14,626,410
Government bonds and other debt securities	13,937,531	3,297,547
U.S. Treasury securities	1,578,977	1,972,995
	25,830,565	19,896,952
Less funds held for current liabilities	7,634,282	7,441,729
Noncurrent portion of assets held under trust indentures	$ 18,196,283	$ 12,455,223
Professional liability trust fund, held by trustee:		
Cash and cash equivalents	$ 119,936	$ 2,532,015
Corporate bonds and other debt securities	5,461,410	6,246,857
Marketable equity securities	1,792,978	4,225,435
	7,374,324	13,004,307
Less funds held for current liabilities	1,185,808	1,411,795
Noncurrent portion of professional liability trust fund	$ 6,188,516	$ 11,592,512
Deferred compensation fund:		
Mutual funds	$ 1,202,063	$ 3,122,185
Corporate bonds and other debt securities	-	263,008
Cash and cash equivalents	39,311	593,715
	$ 1,241,374	$ 3,978,908

The indenture requirements of certain tax-exempt financings provide for the establishment and maintenance of various accounts with a trustee (*Note 10*). These arrangements require the trustee to control the payment of interest and the ultimate repayment of respective debt to bondholders.

The composition of trustee-held funds at December 31, 2008 and 2007 is as follows:

	2008	2007
Debt service reserve fund	$ 6,254,561	$ 6,034,085
Construction fund	513,470	1,030,922
Principal and interest funds	7,634,284	7,441,729
Lease facility escrow	11,428,250	5,390,216
	$25,830,565	$ 19,896,952

Unrestricted investment income and gains and losses for investments, assets whose use is limited, and cash and cash equivalents are comprised of the following in 2008 and 2007:

	2008	2007
Investment income:		
Interest and dividends	$ 9,282,984	$ 7,869,934
Interest on trustee held funds	367,227	537,296
Net realized gains on sale of investments	1,566,827	1,970,391
Write-downs of the cost basis of investments due to an other-than-temporary decline in fair value	(32,269,128)	-
	$ (21,052,090)	$ 10,377,621
Other changes in unrestricted net assets,		
Change in net unrealized gains and losses on investments other than trading securities	$ (11,489,990)	$ 5,047,791

Interest and dividends are net of investment fees of $11,742 in 2008 and $22,609 in 2007.

In March 2009, the Corporation liquidated the short-term investments portfolio. As a result, the losses related to these investments were recognized as a write-down of the cost basis due to an other-than-temporary decline in fair value.

5. Fair Value Measurements and Financial Instruments

Fair Value Measurements

The Corporation measures its short-term investments, assets whose use is limited, investments, beneficial interest in trusts, and derivative financial instruments on a recurring basis in accordance with SFAS No. 157. The financial instruments were measured with the following inputs at December 31, 2008:

	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)
Assets:		
Cash and cash equivalents	$ 40,132,889	$ -
Mutual funds	88,105,081	-
Marketable equity securities	24,946,821	-
Government bonds and other debt securities	-	13,937,531
Corporate bonds and other debt securities	-	5,461,410
U.S. Treasury securities	-	1,578,977
Beneficial interest in trusts	-	1,088,015
Total	$153,184,791	$22,065,933
Liabilities,		
Derivative financial instruments	$ -	$23,206,843

The Corporation did not have any assets or liabilities whose fair values were measured using Level 3 inputs at December 31, 2008.

The Corporation did not have any financial assets or financial liabilities measured at fair value on a non-recurring basis.

Financial Instruments

The carrying amounts reported in the consolidated balance sheets for cash and cash equivalents, patient accounts receivable, accounts payable and accrued expenses, construction payable, accrued compensation and related items, and due to third party payors approximate their related fair values due to the short-term nature of these instruments. Fair values of the variable rate long-term debt are considered to approximate their carrying amounts in the consolidated balance sheets. The fair value of the Corporation's remaining long-term obligations was approximately $18,937,000 and $26,804,000 as of December 31, 2008 and 2007, respectively, and are estimated based on market data provided by the Corporation's financial consultants. In addition to the variable rate debt, the carrying values of the Corporation's HUD mortgages payable also approximate fair value based on similar terms available to the Corporation.

Assets whose use is limited and investments are valued at fair value, which are the amounts reported in the consolidated balance sheet, based on quoted market prices, if available (equity securities and mutual funds), or estimated using quoted market prices of similar securities (corporate bonds, government bonds, U.S. Treasury securities, and other).

Beneficial interest in trusts are valued at fair value, which are the amounts reported in the consolidated balance sheet. The fair value takes into consideration the underlying principal for these assets and the estimated present value of future cash flows. The discount rate used to estimate the present value of future cash flows is based on the rate of return for U.S. Treasury securities with similar maturity horizons. As the underlying principal and discount rate used to calculate fair value are observable inputs, these assets are deemed to be measured with Level 2 inputs as disclosed above.

The Corporation measures its derivative financial instruments at fair value based on proprietary models of an independent third party valuation specialist. The fair value takes into consideration the prevailing interest rate environment and the specific terms and conditions of the derivative financial instrument, and considers the credit risk of the Corporation and counterparty. The method used to determine the fair value calculates the estimated future payments required by the derivative financial instrument and discounts these payments using an appropriate discount rate. The value represents the estimated exit price the Corporation would pay to terminate the agreement.

6. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2008 and 2007 consist of the following:

	2008	2007
Land and improvements	$ 18,765,284	$ 18,554,345
Buildings and improvements	454,500,197	391,193,213
Office furniture and equipment	176,043,366	162,156,530
Equipment under capital leases	43,250,032	41,035,239
	692,558,879	612,939,327
Less accumulated depreciation and amortization	(357,298,769)	(324,318,410)
	335,260,110	288,620,917
Construction in progress	50,358,253	84,800,923
	$ 385,618,363	$ 373,421,840

Depreciation expense, including equipment under capital lease was $32,985,613 in 2008 and $30,296,377 in 2007. Accumulated amortization of equipment under capital lease as of December 31, 2008 and 2007 was $24,775,719 and $18,984,475, respectively. Construction in progress as of December 31, 2008 consists primarily of major renovation and expansion projects of clinical facilities and costs related to the implementation of a new clinical information system.

The Corporation also reports as assets under capital lease the accumulated PHNS, Inc. information technology capital expenditures (*Note 7*), which are being amortized individually to expense over six years.

During the past several years, the Corporation has undertaken several significant construction projects including the construction of a new tower at SGAH and the proposed relocation of the hospital at WAH. As of December 31, 2008, purchase commitments related to these and other miscellaneous projects were approximately $17,000,000. These projects will be funded through transfers from the Corporation's related foundations as well as proceeds from long-term debt.

The Corporation leases a medical office building (the "MOB") to rent space to physicians. The Corporation incurred approximately $5,043,000 in leasehold improvements. The Corporation has experienced lower than expected occupancy which has affected cash flows from rentals at the MOB. Management is aggressively negotiating with potential lessees; however, based on projected rentals management has determined that the fair value of the leasehold improvements at December 31, 2007 was impaired. As a result, an impairment loss of $1,072,347 in 2007 was charged to operations. As of December 31, 2008, and 2007, the carrying value of the MOB leasehold improvements is zero.

On April 29, 2007, AMSI, as a partnership sold its sleep disorder business operations including equipment, intangible assets, and interest in consolidated subsidiary for $14,500,000. The purchaser withheld $1,000,000 in escrow with a third party bank payable in equal installments in 2008 and 2009, and the escrow is subject to future claim deductions as described in the escrow agreement.

The sale resulted in a pretax gain of $12,569,085 and was included in other income in 2007, of which $3,486,714 was allocated to minority interest physician partners based on the sale agreement. This minority interest gain, together with the physician partners' pro rata portion of earnings from operations during the year, amounted to $3,769,034, and is reflected in the accompanying consolidated statements of operations. In April 2008, the purchaser released the second installment of the sale in the amount of $500,000 with no claim deduction. The partnership recognized a gain of $467,038 and was included in other income in 2008, of which $129,633 was allocated to minority interest physician partners based on the sale agreement. The remaining installment gain to be received upon the release of the second escrow without claims in April 2009 is estimated to be $467,038, of which $129,633 is expected to be allocated to minority partners.

AMSI estimated its income tax expenses of $540,000, net of net operating loss carry forward available for the year 2007 and included it as general and administrative expenses in the accompanying consolidated statements of operations. There was no income tax expense in 2008.

7. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments include its interests in unconsolidated subsidiaries and long-term marketable securities at December 31, 2008 and 2007:

	2008	2007
PHNS Inc.	$ 2,736,160	$ 2,736,160
Maryland Regional Cancer Care, LLC	630,953	393,725
Premier, Inc.	1,483,427	977,820
Glade Valley Nursing & Rehabilitation Center, Inc.	651,543	837,693
Germantown Outpatient Imaging	1,174,045	1,198,086
InforMed, LLC	3,000,000	3,000,000
Marketable securities	1,164,774	1,553,068
Other	718,305	370,318
	$11,559,207	$11,066,870

PHNS Inc.

Pursuant to an agreement dated May 4, 2001, the Corporation outsourced its information technology function through a series of transactions with PHNS Inc. (PHNS), a third party provider of information technology, medical record coding, and transcription services to health care providers. This was accomplished through a transaction whereby the Corporation sold its information technology and telephony assets and transferred the ownership of its information technology function to PHNS. In addition, the Corporation engaged PHNS to provide information technology services over a ten-year period. Effective January 1, 2005, the contract has been amended to extend the service agreement through December 31, 2015.

In connection with the sale of these assets, the Corporation received cash of approximately $10,000,000, preferred stock with a face value of approximately $10,000,000, and 336,553 shares of common stock with an estimated value of approximately $1,000,000 as of the date of the transaction. The preferred stock was redeemed in September 2006.

The initial carrying value of the common stock was estimated by management through comparison with publicly traded companies considered by management to be similar to PHNS (which is not publicly traded) at or near the time of sale. No revision of the PHNS common stock holding has been recognized during 2008 or 2007 because in the opinion of management, the fair value of the PHNS common stock has remained consistent. At December 31, 2008 and 2007, the fair value of the Corporation's investment in PHNS' common stock was $2,736,160 which represents an investment of approximately 2% of PHNS' total stock outstanding.

As a result of above, the Corporation is obligated to purchase information technology services from PHNS for a minimum of ten years at an initial cost of approximately $21,000,000 annually. Future payments under this arrangement include annual updates to the fees for the increased cost over time to be reviewed by PHNS for providing the agreed-upon services, plus administrative and other charges. Through 2007, PHNS provided the Corporation with an annual information technology capital budget, each with a three-year installment payment plan. As of December 31, 2008, the Corporation has an obligation to make one final installment payment on the 2007 capital budget in 2009. The Corporation has made a total of $32,867,175 in payments related to this capital budget as of December 31, 2008. Each payment is scheduled to be amortized over a six-year period; cumulative amortization related to these capital payments amounted to $22,136,599 and $17,619,947 as of December 31, 2008 and 2007, respectively. Amortization expense in the amount of $4,516,652 and $4,842,770 has been recognized by the Corporation for the years ended December 31, 2008 and 2007, respectively. Unpaid amounts related to budget years that have already expired amounted to $556,997 and $2,032,504 at December 31, 2008 and 2007, respectively. Beginning in 2005, unpaid capital budget amounts did not incur a financing charge. Interest was imputed based on the Corporation's estimated incremental borrowing rate of 7.4% for 2008 and 2007, respectively. The unpaid capital budget obligations at December 31, 2008 and 2007 had a present value of $535,298 and $1,915,255 respectively.

Effective August 11, 2006, AHC amended the service agreement to exclude purchases and financing of information technology capital expenditures through PHNS. This resulted in the elimination of annual information technology capital budget as described above.

Maryland Regional Cancer Care, LLC

The Corporation owns 50% of a non-profit joint venture, Maryland Regional Cancer Care, LLC (MRCC), with an area hospital. MRCC provides outpatient radiation oncology services to patients in Maryland. Since the Corporation does not control MRCC, the Corporation accounts for its interest under the equity method of accounting. The Corporation recognized earnings of $ 413,174 in 2008 and $927,823 in 2007, which are included in other revenue in the accompanying consolidated statements of operations. Summarized financial information as of December 31, 2008 and 2007 for MRCC is as follows:

	2008	2007
Net revenue	$ 128,540	$ 14,911,409
Net income	(229,608)	2,257,030
Total assets	410,939	17,691,274
Total liabilities	24,438	5,174,657

On December 31, 2007, MRCC wound down their operations and as a result transferred all the assets and liabilities relating to their Rockville location to AHC. Subsequent to this date, MRCC continues to hold an investment in a joint venture, Chesapeake Potomac Regional Cancer Center. The investment balance as of December 31, 2008 represents AHC's portion of the equity MRCC has in this joint venture.

Premier, Inc.

The Corporation is a partner in Premier, Inc. (Premier), a health care system group purchasing organization. Partners are required to maintain capital accounts with Premier. The Corporation maintains approximately .6% and .8% of the total capital of Premier at December 31, 2008 and 2007, respectively. Excess earnings after expenses associated with the purchasing program are credited to partners' capital accounts based on partners' pro rata volume of purchases. Premier's board establishes a required capital every six months. Capital balances in excess of the required capital is distributed semi-annually. The Corporation accounts for its interest in Premier under the cost method of accounting. The Corporation recognized earnings of $ 2,734,427 in 2008 and $605,897 in 2007, which are included in other revenue in the accompanying consolidated statements of operations.

Glade Valley Nursing & Rehabilitation Center, Inc.

The Corporation and another area hospital are the sole equal members of Glade Valley Nursing & Rehabilitation Center, Inc. (Glade). Glade is organized for the purpose of operating a 124 comprehensive bed nursing facility in Walkersville, Maryland, and is managed by ASLS. The Corporation accounts for its interest under the equity method of accounting. The Corporation recognized earnings of $111,505 in 2008 and $413,052 in 2007, which are included in other revenue in the accompanying consolidated statements of operations. Summarized financial information for Glade for 2008 and 2007 is as follows:

	2008	2007
Net revenue	$ 12,906,517	$ 11,837,051
Net income	222,959	826,105
Total assets	11,195,489	11,201,528
Total liabilities	9,395,714	9,526,142

Germantown Outpatient Imaging, LLC

In August 2006, the Corporation entered into an agreement with a physician radiology group for the creation of a joint venture that would provide radiology and other imaging services to patients on an outpatient basis. Germantown Outpatient Imaging (GOI) is 50% owned by the Corporation and 50% owned by a physician radiology group. The Corporation accounts for its investment in this joint venture on the equity method of accounting. The Corporation recognized earnings of $478,078 in 2008 and $372,078 for 2007. Summarized financial information for GOI for 2008 and 2007 is as follows:

	2008	2007
Net revenue	$ 3,890,581	$ 3,070,990
Net income	932,828	853,692
Total assets	2,588,004	2,560,280
Total liabilities	237,827	164,109

The Corporation invests in other joint ventures with the area's health care providers. The Corporation accounts for its interest in these joint ventures under the cost method of accounting.

InforMed, LLC

On January 1, 2007, the Corporation paid $3,000,000 to purchase a 10% membership interest in InforMed, LLC, which is a provider of chronic disease and medical management, clinical claims data warehousing and analysis, network management, and third-party administration based in Annapolis, Maryland. AHC accounts for this investment in InforMed, LLC, on the cost basis method of accounting.

Summarized financial information for InforMed, LLC for 2008 and 2007 is as follows:

	2008	2007
Net revenue	$ 17,526,672	$ 11,546,659
Net income	1,704,243	(390,627)
Total assets	6,729,849	6,255,689
Total liabilities	3,939,875	3,770,111

Marketable Securities

The Foundations also hold marketable debt and equity securities for funds not required to be expended in less than 90 days. These marketable securities are subject to credit and market risks.

8. Land Held for Healthcare Development

On February 25, 2002, the Corporation purchased 209 acres of land in Clarksburg, Maryland for approximately $20,000,000. Concurrent with this purchase, the Corporation entered into a sale agreement with an unrelated third party to be used for residential construction for the sale of 91 acres for $16,000,000.

On December 27, 2004, the Corporation purchased an additional adjacent parcel of land in Clarksburg Maryland for $8,000,000. The purchase price and the related closing costs were financed under a line of credit with a commercial bank. Total costs capitalized related to the above parcels of land and improvements on this land was $37,027,449 and $34,937,970 at December 31, 2008 and 2007, respectively.

In July 2006, the Corporation purchased a parcel of land near the Calverton-White Oak area of Silver Springs for approximately $11,000,000. The Corporation plans to build a replacement hospital for Washington Adventist Hospital. The cost of the land will continue to be reported as land held for healthcare development until such time as the Maryland Health Care Commission approves the Corporation's plan for constructing the new facility. As of December 31, 2008 and 2007, the Corporation had total costs capitalized related to this land and land improvements of $18,580,990 and $12,385,536, respectively.

On December 29, 2008, the Corporation participated in a group purchase of 5.31 acres of property located in Boyds, Maryland. The parcel was purchased by Cabin Branch Management, LLC, a Maryland Limited Liability Company of which the Corporation is a voting member. The Corporation does not maintain control of this Limited Liability Company and, therefore, the operation of it is not included in the consolidated financial statements at December 31, 2008 and 2007. The Corporation contributed $205,045 of the total contracted sales price of $735,000.

9. Short-Term Financing

The Corporation has a $3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50%. There were no borrowings outstanding under this line of credit as of December 31, 2008 or 2007.

In December 2008, the Corporation entered into a $20,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 3.00% (3.5% at December 31, 2008), with a term of one month. This line of credit expires on March 1, 2009. Borrowings under this line of credit were $20,000,000 at December 31, 2008.

10. Long-Term Obligations

Long-term obligations as of December 31, 2008 and 2007 are comprised of the following:

	2008	2007
$22,925,000 Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds, Series 2003A Washington Adventist Hospital (WAH); interest on bonds ranging from 5% to 5.75% with interest payments due semiannually on January 1 and July 1; annual principal and sinking fund payments ranging from $1,000,000 to $2,130,000 due annually from January 1, 2009 to January 1, 2025.	$ 22,925,000	$ 22,925,000
$39,560,000 Maryland Health and Higher Educational Facilities Authority Revenue Bonds, Series 2003B Adventist HealthCare, Inc.; interest is payable monthly at a variable rate based on the SIFMA index (1.71% at December 31, 2008); annual principal payments ranging from $955,000 to $1,985,000 due annually from January 1, 2009 to January 1, 2033.	35,310,000	36,240,006
$50,000,000 Maryland Health and Higher Educational Facilities Authority Revenue Bonds, Series 2004A Adventist HealthCare; interest on is payable monthly at a variable rate based on the SIFMA index (1.20% at December 31, 2008); annual principal payments ranging from $190,000 to $4,880,000 due from January 1, 2009 to January 1, 2035.	39,915,000	45,405,000
$35,985,000 Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds, Series 2004B Adventist HealthCare; interest is payable monthly at a variable rate based on LIBOR (2.25% at December 31, 2008); annual principal payments ranging from $820,000 to $1,910,000 are due annually from January 1, 2009 through January 1, 2035.	29,990,000	29,990,000
$78,000,000 Maryland Health and Higher Educational Facilities Authority Revenue Bonds, Series 2005A Adventist HealthCare; interest is payable monthly at a variable rate based on the SIFMA index (1.10% at December 31, 2008); annual principal payments ranging from $1,050,000 to $10,755,000 are due annually from January 1, 2022 through January 1, 2035.	78,000,000	78,000,000

(Continued)	2008	2007
$64,590,000 Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds, Series 2005B Adventist HealthCare; interest is payable monthly at a variable rate based on the SIFMA index (1.20% at December 31, 2008); annual principal payments ranging from $5,630,000 to $10,800,000 are due annually from January 1, 2013 through January 1, 2021.	$59,330,000	$59,330,000
$5,105,000 Montgomery County, Maryland Economic Development Revenue Bonds, Series 1993 Springbrook Adventist Nursing and Rehabilitation Center, Inc. (Springbrook); interest on term bonds ranging from 5.875% to 6.5% with interest payments due semiannually on April 1 and October 1 of each year; mandatory annual principal and sinking fund payments ranging from $155,000 to $365,000 from October 1, 2009 through October 1, 2023.	3,685,000	3,830,000
$13,343,900 US Department of Housing and Urban Development, Federal Housing Administration Loan, Bradford Oaks Nursing and Rehabilitation Center, Inc., interest on loan at 5.45%; monthly principal and interest payments of $75,347 from January 1, 2008 through January 1, 2037.	12,987,306	13,177,988
$9,079,900 US Department of Housing and Urban Development, Federal Housing Administration Loan, Shady Grove Adventist Nursing and Rehabilitation Center, Inc., interest on loan at 5.45%; monthly principal and interest payments of $51,270 from January 1, 2008 through January 1, 2037.	8,837,254	8,967,004
$1,170,000 US Department of Housing and Urban Development, Federal Housing Administration Loan, Shady Grove Adventist Nursing and Rehabilitation Center, Inc. interest on loan at 5.95%; monthly principal and interest payments of $7,160 from June 2008 through May 2036.	1,160,346	-
$5,766,200 US Department of Housing and Urban Development, Federal Housing Administration Loan, Sligo Creek Nursing and Rehabilitation Center, Inc., interest on loan at 5.45%; monthly principal and interest payments of $32,559 from January 1, 2008 through January 1, 2037.	5,612,108	5,694,505
Note payable to finance the implementation of a new clinical system. The equipment has been financed through several agreements with different terms in regard to the amortization period and the rates of interest to be paid. None of the related financing extends beyond 10 years.	17,108,696	21,201,716
$20,000,000 unsecured line of credit with a commercial bank with interest at LIBOR plus 0.75% (2.65% at December 31, 2008). Borrowings under this line of credit are due on December 31, 2010.	20,000,000	9,995,000
$20,000,000 secured line of credit with a commercial bank with interest at LIBOR plus 0.45% (2.35% at December 31, 2008). Borrowings under this line of credit are due on December 31, 2010.	20,000,000	20,000,000
$16,000,000 secured line of credit with a commercial bank with interest at LIBOR plus 0.75% (2.65% at December 31, 2008). Borrowings under this line of credit are due on March 12, 2010.	16,000,000	-

(Continued)	2008	2007
$12,000,000 Capital Lease Purchase Financing Facility with Sun Trust Leasing Corporation with interest at 4.31% and monthly principal and interest payments of $222,681. The repayment period commenced on June 30, 2007 and extends through June 30, 2012.	$ 8,666,940	$ 10,912,793
$8,000,000 Capital Lease Purchase Financing Facility with Sun Trust Leasing Corporation with interest at 3.85% and monthly principal and interest payments of $146,791. The repayment period commenced on November 30, 2008 and extends through October 31, 2013.	7,757,364	-
Other notes payable due in varying monthly principal payments through 2014	928,306	1,052,911
Capital lease obligation related to unpaid portion of PHNS annual capital budget	535,298	1,915,255
Capital leases payable, secured by related capital equipment.	1,318,156	1,742,578
TOTAL OBLIGATIONS	390,066,774	370,379,756
Less current maturities	81,075,497	15,159,177
Less bond discount	236,590	246,380
NONCURRENT PORTION OF LONG TERM OBLIGATIONS, Net	$308,754,687	$354,974,199

SGAH, WAH, and Potomac Ridge were the initial members of an Obligated Group as described in the Master Trust Indenture (the Original Master Trust Indenture) dated September 1, 1991, and a First Supplemental Master Trust Indenture (the Supplemental Master Trust Indenture) dated November 17, 1993. Through the issuance of supplemental indentures, Shady Grove Adventist Nursing and Rehabilitation Center (SGANRC), the Support Center, and HRMC have been added to the Obligated Group. In February 2003, the Amended and Restated Master Trust Indenture was established and took effect in December 2005 when the majority of the Obligated Group debt was defeased.

In 2003, the Maryland Health and Higher Educational Facilities Authority (the Authority) issued two new series of bonds for the benefit of the Obligated Group: 2003A Series tax-exempt Refunding Revenue Bonds for $22,925,000, and 2003B Series tax-exempt Revenue Bonds for $39,560,000. The payment of the principal and interest on the 2003B Bonds is secured by a separate irrevocable direct-pay Letter of Credit, which will expire on March 1, 2013.

In September 2004, the Fourth Supplemental Master Trust Indenture was executed, at which time ARHM was added to the Obligated Group. Pursuant to the agreements between this new Obligated Group and the Authority, the Authority issued two new series of bonds for the benefit of the Obligated Group: 2004A Series tax-exempt Revenue Bonds for $50,000,000 and 2004B Series taxable Revenue Refunding Bonds for $35,985,000. The payment of the principal and interest on the bonds of each series is secured by a separate irrevocable direct-pay Letter of Credit. The Letters of Credit will expire on September 14, 2009. As such, the outstanding debt related to these bonds has been classified as current as of December 31, 2008. The 2004B bonds were issued to refund in advance the non-callable City of Gaithersburg and City of Takoma Park 1995 Series for SGAH, SGANRC and WAH. On December 19, 2006, SGANRC closed on a loan of $9,079,900 through the US Department of Housing and Urban Development (HUD). The proceeds from the SGANRC loan were used to make partial payments of $2,995,000 and $5,260,000 on the Series 2004B and 2005B, respectively.

On December 23, 2004, the Fifth Supplemental Master Trust Indenture was executed to secure the obligations of the Corporation under a Line of Credit.

In December 2005, the Series 2005A and B were issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. SGANRC withdrew from the Obligated Group concurrent with the issuance of the Series 2005 bonds. The payment of principal and interest for the Series 2005A and 2005B bonds are both secured by irrevocable direct-pay Letters of Credit which expire on December 20, 2010. In addition, the Amended and Restated Master Trust Indenture imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with the required covenants for the year ending December 31, 2008 and 2007.

On March 1, 2008 the Second Supplemental Master Trust Indenture was executed to extend the term of the agreement securing the obligations of the Corporation under a Line of Credit executed on December 23, 2004 and to secure the obligation of a new loan to finance the costs of construction of a parking garage at SGAH.

Springbrook Nursing & Rehabilitation Center ("Springbrook") and Sligo Creek Nursing & Rehabilitation Center ("Sligo") are the initial members of an Obligated Group as described in the Master Trust Indenture (the Indenture) dated October 1, 1993 for the 1993 Economic Development Revenue Bonds. In accordance with the terms of the Indenture, the members of the Obligated Group have granted a security interest to the Trustee in all property and unrestricted revenue of the Obligated Group. In addition, the Indenture imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. On December 19, 2006, Sligo closed on a loan of $5,766,200 through the US Department of Housing and Urban Development (HUD). As part of this transaction, Sligo paid off existing bonds and withdrew from the Obligated Group leaving Springbrook as the Obligated Group Representative. Additional details of this transaction are described below. As of December 31, 2008 and 2007, in the opinion of management, the Obligated Group was in compliance with the financial covenants.

On July 10, 1997, the Authority issued $13,780,000 of Nursing Facility Mortgage Revenue Bonds. The bond proceeds were used to finance the costs of the acquisition of Bradford Oaks Nursing & Rehabilitation Center (Bradford), to finance the construction and equipment of an expansion project, to fund working capital costs with respect to the Bradford facility, to establish a Debt Service Fund for the Series 1997 Bonds, to fund capitalized interest on a portion of the Series 1997 Bonds, and to pay a portion of the costs associated with the issuance of the Bonds. The Bonds were secured by a pledge of the receipts of Bradford and by a mortgage on the facility. The Bonds require that Bradford achieve certain pre-established financial indicators. On December 19, 2006, Bradford closed on a $13,343,900 loan through HUD and paid off Bradford's existing bonds. Additional details of this transaction are described below.

As mentioned above, on December 19, 2006 Bradford, SGANRC, and Sligo entered into loans with HUD for $13,343,900, $9,079,900, and $5,766,200, respectively. The loans are secured by mortgages on each facility. The majority of the proceeds of each loan were used to pay off each of the facilities existing bond obligations as well as provide for various capital needs of the facilities.

In December 2006, the Montgomery County Economic Development Revenue Bonds, Series of 1993 (the "Series 1993 Bonds") and the Maryland Health and Higher Educational Facility Authority Nursing Facility Mortgage Revenue Bonds, Series of 1997 (the "Series 1997 Bonds"), in the amount of $10,495,000 and $13,780,000, respectively, were refunded through a mortgage agreement between Adventist HealthCare, Inc. and Capstone Realty Advisors, LLC, secured by the Secretary of Housing and Urban Development under Section 232 pursuant to Section 223(f) of the National Housing Act, as amended.

The Corporation has a $20,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 0.75% (2.65% at December 31, 2008). Borrowings under this line of credit were $20,000,000 at December 31, 2008 and $9,995,000 at December 31, 2007. At December 31, 2007, the line of credit was modified and extended through December 31, 2010 at which time any outstanding borrowings are payable in full (Note 9). Interest expense charged to operations under this line of credit was $523,506 and $385,356 for the years ended December 31, 2008 and 2007, respectively.

The Corporation also has a $20,000,000 secured line of credit with a commercial bank, with interest at LIBOR plus 0.45% (2.35% at December 31, 2008). Borrowings under this line of credit were $20,000,000 at December 31, 2008 and 2007. Interest cost of $782,670 and $1,142,986 were capitalized during 2008 and 2007, respectively, under this line of credit because the entire balance is financing the Corporation's development of the land held for healthcare development (Note 8). At December 31, 2007, the line of credit was extended through December 31, 2010 at which time any outstanding borrowings are payable in full (Note 9).

On March 12, 2008, the Corporation entered into a $16,000,000 secured line of credit with a commercial bank with interest at LIBOR plus 0.75% (2.65% at December 31, 2008) to finance the construction of a parking deck on the campus of Shady Grove Adventist Hospital. The line of credit expires on February 28, 2010. Interest expense charged to operations under this line of credit was $352,986 for the year ended December 31, 2008.

In June 2007, the Corporation entered into a Capital Lease Purchase Financing Facility with Sun Trust Leasing Corporation (Sun Trust). Under the terms of the agreement, Sun Trust deposited $12,000,000 into an escrow account for the purpose of funding future purchases of new or used medical or medical-related equipment. Sun Trust retains title to the equipment and is considered to be the owner; however, the Corporation is responsible for all related expenses, including but not limited to, insurance, maintenance, and taxes. Interest accrues at a fixed rate of 4.31% and the Corporation pays monthly principal and interest payments over a five-year period. The Corporation benefits from the interest earned on those funds that remain in escrow (Note 4). As of December 31, 2008, four draws totaling $7,734,488 have been made. Interest expense charged to operations under the leasing facility was $426,321 and $271,865 for the years ended December 31, 2008 and 2007, respectively.

In October 2008, the Corporation entered into a Capital Lease Purchase Financing Facility with Sun Trust. Under the terms of the agreement, Sun Trust deposited $8,000,000 into an escrow account for the purpose of funding future purchases of new or used medical or medical-related equipment. Sun Trust retains title to the equipment and is considered to be the owner; however, the Corporation is responsible for all related expenses, including but not limited to, insurance, maintenance, and taxes. Interest accrues at a fixed rate of 3.85% and the Corporation pays monthly principal and interest payments over a five-year period. The Corporation benefits from the interest earned on those funds that remain in escrow (Note 4). As of December 31, 2008, draws totaling $8,000,000 have been made. Interest expense charged to operations under the leasing facility was $63,778 for the year ended December 31, 2008.

Scheduled principal repayments of long-term obligations at December 31, 2008 are as follows:

YEARS ENDING DECEMBER 31	
2009	$ 81,075,497
2010	67,218,410
2011	10,948,402
2012	7,963,291
2013	9,647,813
Thereafter	213,213,361
	$390,066,774

11. Derivative Financial Instruments

The Corporation entered into four interest rate swap agreements, which are considered derivative financial instruments. The agreements were entered into in order to manage interest rate exposure. The principal objective of the swap agreements is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreements is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. Management believes that losses related to credit risk are remote.

Management has designated two of the interest rate swap agreements as cash flow hedges, which qualify for hedge accounting treatment under Statement of Financial Accounting Standard No. 133, Accounting *for Derivative Instruments and Hedging Activities.* These two interest rate swap agreements are reported at fair value in the consolidated balance sheets. The effective portion of the change in fair value of these derivatives is reported in the consolidated statements of operations and changes in net assets as an unrealized gain or loss on cash flow derivative financial instrument. The ineffective portion of the change in fair value is reported in the accompanying consolidated statements of operations as a component of interest expense.

For the two interest rate swaps not designated as cash flow hedges, changes in fair value are reported as a component of other nonoperating income in the accompanying consolidated statements of operations.

The net cash paid or received under the swap agreements is recognized as an adjustment to interest expense. The net cash paid under the interest rate swap agreements was $1,489,083 in 2008 and $310,313 in 2007, which is reported as a component of interest expense in the accompanying consolidated statements of operations.

At December 31, 2008 and 2007, the Corporation's derivative financial instruments and related fair values are as follows:

	2008	2007
Agreement with Lehman Brothers, Inc. for the notional amount of $78,000,000 requiring the Corporation to pay a fixed interest rate of 3.567% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2035 and qualifying for cash flow hedge accounting treatment	$ -	$(3,306,336)
Agreement with notional amount of $59,330,000 requiring the Corporation to pay a fixed interest rate of 3.457% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2021 and qualifying for cash flow hedge accounting treatment	(7,342,573)	(1,951,386)
Agreement with notional amount of $78,000,000 requiring the Corporation to pay variable interest rates based upon 67% of monthly LIBOR while receiving variable interest rates based upon 62.11% of the five-year ISDA rate, maturing January 2035; does not qualify for cash flow hedge accounting treatment	1,056,201	746,393

	2008	2007
Agreement with Deutsche Bank for the notional amount of $78,000,000 requiring the Corporation to pay a fixed interest rate of 3.567% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2035 and qualifying for cash flow hedge accounting treatment	$(16,920,471)	$ -
	$(23,206,843)	$(4,511,329)

The fair value of the interest rate swap agreements is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation (Note 5). To the extent that the interest rate swaps qualifying for cash flow hedge accounting treatment are effective in converting the variable interest rate to a fixed rate, the unrealized gain or loss on the derivative financial instruments is excluded from revenues in excess of expenses. Gains or losses resulting from hedge ineffectiveness are recognized in revenues in excess of expenses. Losses of $1,213,867 were recognized as of December 31, 2008 and gains of $170,516 were recognized as a component of revenues in excess of expenses in 2007 as a result of hedge ineffectiveness. Gains or losses resulting from interest rate swap agreements not qualifying for cash flow hedge accounting treatment are entirely recognized as a component of revenues in excess of expenses. The income statement impact of swaps not qualifying for hedge accounting treatment was a $381,509 gain in 2008 and a $264,543 loss in 2007. There are no triggers in the swap agreements that would result in collateral posting by the Corporation.

On October 3, 2008, the counterparty for the Corporation's fixed pay swap maturing in January 2035, Lehman Brothers, Inc., commenced proceedings under Chapter 11 of the Bankruptcy Code. This action triggered an Event of Default under the ISDA Master Agreement in effect with said party and gave the Corporation the right to terminate the transaction. On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a gain of $472,023 which is included in unrestricted net assets in the consolidated balance sheet. This gain will be amortized over the remaining term of the 2005A Series Bonds, or through January 2035. As of December 31, 2008, accumulated amortization of $2,967 is included in other changes in net assets and interest expenses in the consolidated statement of operations and changes in net assets.

12. Leases

The Corporation has entered into various operating leases primarily for office space as well as certain equipment items. Rental expense for operating leases was $16,222,260 in 2008 and $15,278,761 in 2007. Future minimum payments under non cancelable operating leases with initial or remaining terms of one year or more consist of the following during the years ending December 31:

YEARS ENDING DECEMBER 31	
2009	$ 10,781,704
2010	10,042,696
2011	10,097,640
2012	10,149,889
2013	7,812,429
Thereafter	67,754,595
	$116,638,953

The Corporation has also entered various sub-lease agreements with tenants that occupy space in the Corporation's buildings. The terms of these sub-leases vary and extend through 2024. Rental income was $2,935,837 in 2008 and $2,958,572 in 2007, which has been reported as a component of other operating revenue in the consolidated statements of operations. Future rent payments expected to be received by the Corporation during the years ending December 31 is as follows:

YEARS ENDING DECEMBER 31	
2009	$ 3,347,937
2010	3,088,413
2011	2,695,326
2012	2,567,552
2013	2,126,055
Thereafter	6,813,258
	$20,638,541

13. Retirement and Health Plans

Defined Contribution Retirement Plan

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After 12 months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2% of eligible employees' compensation, plus a matching employer contribution equal to 50% of employee contributions up to 6% of base salary. Retirement plan expense was $7,630,625 in 2008 and $6,716,024 in 2007.

ASLS participates in a contributory 403(b) tax deferred annuity retirement plan administered by an insurance company. Employer contributions are 100% matched to employee contributions up to 4% of base salary. Retirement plan expense was $419,715 in 2008 and $391,165 in 2007.

AHHS employees are covered by a separate defined contribution plan. Retirement plan expense was $201,224 in 2008 and $176,437 in 2007.

AMSI employees are covered by a 401(k) defined contribution plan. Retirement plan expense was $16,570 in 2008 and $23,387 in 2007.

Salary Deferral (457(b)) Plan

Employees who contribute the maximum allowable amount to the 403(b) retirement plan have an opportunity to contribute additional funds on a tax-deferred basis to a 457(b) retirement plan up to the maximum tax-sheltered opportunity. There are no employer contributions to this plan.

Employee Life and Health Benefit Program

The Corporation maintains a self-insurance employee program for its health insurance overage. The Corporation accrues the estimated costs of incurred and reported and incurred but not reported claims, after consideration of its stop-loss insurance coverage, based upon data provided by the third-party administrator of the program, and historical claims experience. Beginning January 1, 2005, HRMC maintained its own self-insurance program for employee health care coverage.

Deferred Compensation Plan

The Corporation maintains the Adventist HealthCare, Inc. deferred compensation plan (the Plan). The Plan provides cash compensation and other benefits to eligible employees after termination of employment. Fund assets are invested in money market securities held by an irrevocable trust, subject to claims made by the employer's creditors in the event of bankruptcy or insolvency. It is the Corporation's policy to fund the Plan based on actuarially determined amounts sufficient to satisfy its obligations in the plan year.

AHC Executive Flex Benefit Program

The AHC Executive Flex Benefit Program (the Program) was implemented to provide additional benefits to eligible employees as defined by the Program. Plan documentation provides for a financial benefit floor equal to 5% of net salary. Funding for benefits earned under this Program are made on a quarterly basis based on actual benefits earned for the year.

14. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for betterments to plant facilities and purchases of equipment or to support operating programs sponsored by the Corporation and its affiliates.

Permanently restricted net assets have been restricted by donor to be maintained by the Corporation in perpetuity.

Net assets were released from donor restriction by satisfying their restricted purposes in the amount of $5,498,554 in 2008 and $4,413,039 in 2007.

15. Commitments and Contingencies

Litigation and Claims

The Corporation is subject to asserted and unasserted claims (in addition to litigation) encountered in the ordinary course of business. In the opinion of management and after consultation with legal counsel, the Corporation has established adequate reserves related to all known matters. The outcome of any potential investigative, regulatory or prosecutorial activity that may occur in the future cannot be predicted with certainty, however, any associated potential future losses resulting from such activity could have a material adverse effect on the Corporation's future financial position, results of operations and liquidity.

As part of the Corporation's ongoing corporate compliance efforts during 2003, it was discovered that the Medicare program had been billed for a non-covered procedure furnished to Medicare beneficiaries. The billing mistake, which appears to have occurred over a several year period, has been rectified. The Corporation has initiated discussions with the appropriate regulatory agencies regarding the billing error, and will refund any payments received from the Medicare program as a result of the error. After consultation with legal counsel, it has been estimated that the Corporation may have to refund $2,400,000 to $3,200,000 to the Medicare program related to this billing matter. The accompanying consolidated financial statements reflect a $3,200,000 reserve to account for this potential exposure, which has been reported as a noncurrent liability on the consolidated balance sheets.

Insurance

The Corporation's primary coverage for professional liability is provided through a self-funded insurance retention trust (the "Trust") established on January 1, 1993. The Trust is funded based on actuarial estimates and provides coverage of $2,000,000 per occurrence with no annual aggregate limitation. The Trust also provides general liability coverage up to $1,000,000 per occurrence. The Corporation also carries umbrella excess liability insurance on a claims made basis with a commercial carrier, with limits of $20,000,000 per occurrence and in aggregate.

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2008, management determined that the fully-funded professional liability reserve reported at December 31, 2008 and 2007 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was $9,583,981 and $11,327,818 at December 31, 2008 and 2007, respectively. The discount rate used in determining these liabilities was 4.5% and 5.0% at December 31, 2008 and 2007, respectively.

The Corporation is self-insured for unemployment and workers' compensation benefits. The liability for unemployment and worker's compensation claims payable is an estimate based on the Corporation's past experience and is included in the accompanying consolidated balance sheets. It is reasonably possible that the estimates used could change materially in the near term.

Guaranteed Occupancy Clause

During 2002 and 2003, HRMC entered into agreements to guarantee the occupancy of two medical office buildings located in Hackettstown, New Jersey. The agreement entered into in 2002 is effective for 15 years, and the agreement entered into in 2003 is effective for 20 years.

For the agreement entered into in 2002, HRMC agreed to lease each tenant space that becomes vacant for at least 60 days during the term of the agreement at an annual base rent of $13.75 per square foot of rentable floor area during the first year of the agreement. Each year thereafter, the base rent will increase by 3% of the prior year's base rent. The owner of this medical office building is obligated to use commercially reasonable efforts to lease any tenant space that becomes vacant during the term of the agreement. All tenant space has been occupied as of December 31, 2007 and 2006.

For the agreement entered into in 2003, HRMC agreed to lease each tenant space that becomes vacant for at least 60 days during the term of the agreement at an annual base rent of $14.75 per square foot of rentable floor area during the first year of the agreement, and at $18.00 per square foot of rentable space for the second year of the agreement. Each year thereafter, the base rent will increase by the consumer price index. The owner of this medical office building is obligated to use commercially reasonable efforts to lease any tenant space that becomes vacant during the term of the agreement. This agreement became effective upon the completion of the medical office building in October 2004.

With regard to the guaranteed occupancy clauses, HRMC has recognized a liability in accordance with FASB Interpretation 45: *Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others.* This liability totaled $699,568 and $699,283 at December 31, 2008 and 2007, respectively. The liability represents the present value of the estimated guarantee payments over the term of the guarantee. This liability has been offset by a deferred asset of the same amount, which is reported as a component of unamortized intangible assets in the accompanying consolidated balance sheets.

16. Business and Credit Concentrations

The Corporation grants credit to patients, substantially all of whom are local residents. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies.

At December 31, 2008 and 2007, concentrations of gross receivables from third-party payers and others are as follows:

	2008	2007
Medicare	21%	22%
Medicaid	17%	15%
Other third party payers	46%	44%
Self-pay and others	16%	19%
	100%	**100%**

Gross patient service revenue, by payer class, consisted of the following for the years ended December 31:

	2008	2007
Medicare	38%	37%
Medicaid	8%	8%
Other third party payers	45%	47%
Self-pay and others	9%	8%
	100%	**100%**

The Corporation maintains its cash and cash equivalents with several financial institutions. Cash and cash equivalents on deposit with any one financial institution are insured up to $250,000.

17. Functional Expenses

A summary of the Corporation's operating expenses by function for the years ended December 31 is as follows:

	2008	2007
Hospital acute and ambulatory services	$609,759,959	$ 580,288,723
Home care services	13,281,901	12,240,881
Long-term care facilities	55,349,929	53,853,142
Other health care services	104,186,391	101,355,629
Other	19,125,474	17,943,039
	$801,703,654	**$ 765,681,414**

PARENTERANDOLPH

The Power of Ideas

Independent Auditors' Report on Additional Information

Board of Trustees
Adventist HealthCare, Inc.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating and combining information presented on pages 45 through 60 is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, changes in net assets, and cash flows of the individual entities. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Parente Randolph, LLC

Wilkes-Barre, Pennsylvania
May 13, 2009

ADVENTIST HEALTHCARE, INC.
Schedule of Consolidating Information, Balance Sheet
December 31, 2008

ASSETS	Consolidated Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Laurel Center	Adventist Rehabilitation Hospital of Maryland	Adventist Home Health Services	Adventist Physician Services	Consolidated Adventist Senior Living Services	Consolidated Adventist Management Services, Inc.	SGAH, WAH, PRRH and HCH Foundations
CURRENT ASSETS:														
Cash and cash equivalents	$ 15,671,658	$ -	$ (60,404,614)	$ 16,443,484	$ 11,422,791	$ 29,253,192	$ 412,934	$ 1,450	$ 4,093,241	$ 1,746,392	$ (3,359,314)	$ 14,554,491	$ (86,799)	$ 1,600,410
Short-term investments	139,716,646	-	139,716,646	-	-	-	-	-	-	-	-	-	-	-
Assets whose use is limited	8,820,990	-	6,958,853	-	1,763,147	-	-	-	-	-	-	-	-	-
Patient accounts receivable, net of estimated allowances of $64,588,000	115,357,553	-	108,815	41,939,609	38,304,690	11,113,917	5,320,812	-	7,294,541	1,654,327	1,016,198	8,536,150	8,494	-
Other receivables, net of estimated allowance for uncollectible accounts of $1,286,000	9,633,899	(7,014,976)	388,080	1,616,704	1,758,204	391,393	3,818,938	1,160,903	102,032	103,560	36,937	13,528	1,989,192	268,504
Due from third party payors	-	(463,781)	-	-	-	-	-	-	463,781	-	-	-	-	-
Inventories	10,800,753	-	-	4,568,777	3,468,533	2,279,736	129,013	-	84,295	21,540	-	32,954	215,925	-
Prepaid expenses and other current assets	3,548,970	-	1,992,409	271,722	374,801	450,296	145,838	624	85,267	25,622	10,346	123,613	55,981	9,396
TOTAL CURRENT ASSETS	303,549,369	(2,477,857)	88,820,049	64,840,296	57,092,146	43,488,534	9,830,535	1,162,977	12,123,152	3,545,441	(2,295,833)	23,356,826	2,182,793	1,878,310
PROPERTY AND EQUIPMENT, Net	385,618,363	-	56,849,554	185,123,745	41,949,436	52,672,801	11,208,400	2,006,353	9,260,372	394,619	73,614	25,843,460	233,009	-
ASSETS WHOSE USE IS LIMITED:														
Under trust indentures, held by trustee	18,196,283	-	3,475,784	5,230,735	5,321,295	1,195,498	286,582	-	398,765	-	-	2,287,624	-	-
Professional liability trust fund	6,188,516	-	6,188,516	-	-	-	-	-	-	-	-	-	-	-
Deferred compensation fund	1,241,374	-	-	47,784	1,193,590	-	-	-	-	-	-	-	-	-
CASH AND CASH EQUIVALENTS TEMPORARILY RESTRICTED FOR CAPITAL ACQUISITION	2,456,185	-	-	533,717	-	1,161,096	-	562,760	86,559	-	-	-	-	112,051
INVESTMENTS AND INVESTMENTS IN UNCONSOLIDATED SUBSIDIARIES	11,569,207	-	6,323,492	1,174,048	-	2,150,595	28,102	-	-	-	-	718,188	-	1,164,775
LAND HELD FOR HEALTHCARE DEVELOPMENT	55,813,484	-	48,203,267	-	7,610,217	-	-	-	-	-	-	-	-	-
DEFERRED FINANCING COSTS, Net	4,597,100	-	121,209	1,310,806	985,782	519,498	96,626	-	91,670	-	-	1,501,312	-	-
INTANGIBLE ASSETS, Net	7,968,423	-	99,752	3,178,476	60,133	699,283	2,422,179	-	1,135,381	229,884	-	-	143,333	-
DERIVATIVE FINANCIAL INSTRUMENT	-	(1,066,220)	1,066,220	-	-	-	-	-	-	-	-	-	-	-
DEPOSITS AND OTHER NONCURRENT ASSETS	9,113,310	(338,210)	1,451,507	513,983	562,281	3,131,364	376,864	-	52,000	62,151	6,887	9,065	19,075	3,286,323
TOTAL	$ 806,101,612	$ (3,882,287)	$ 212,599,350	$ 264,953,589	$ 164,744,880	$ 105,018,576	$ 24,249,408	$ 3,734,090	$ 23,128,099	$ 4,232,095	$ (2,215,332)	$ 53,519,675	$ 2,578,210	$ 6,441,459

ADVENTIST HEALTHCARE, INC.
Schedule of Consolidating Information, Balance Sheet
December 31, 2008

	Consolidated Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Louie Center	Adventist Rehabilitation Hospital of Maryland	Adventist Home Health Services	Adventist Physician Services	Consolidated Adventist Senior Living Services	Consolidated Adventist Management Services, Inc.	SGAH, WAH, PRBH and HGH Foundations
LIABILITIES AND NET ASSETS														
CURRENT LIABILITIES:														
Accounts payable and accrued expenses	$ 66,089,839	$ (1,443,922)	$ 13,680,198	$ 21,146,655	$ 17,089,389	$ 5,204,762	$ 1,978,906	$ 1,594,630	$ 517,332	$ 844,555	$ 159,100	$ 4,305,646	$ 1,003,583	$ 9,025
Accrued compensation and related items	33,046,052	(570,154)	4,821,098	9,725,042	8,220,389	3,972,350	2,642,541	242,263	1,151,239	865,099	215,975	2,445,139	185,071	-
Interest payable	1,266,196	-	1,135,635	-	-	-	-	-	-	-	-	130,561	-	-
Due to third party payors	16,581,868	(463,781)	-	9,433,085	6,724,149	151,035	40,104	-	-	-	-	697,276	-	-
Estimated self-insured professional liability	1,185,808	-	1,185,808	-	-	-	-	-	-	-	-	-	-	-
Short-term financing	20,000,000	-	20,000,000	-	-	-	-	-	-	-	-	-	-	-
Current maturities of long-term obligations	81,075,497	-	13,287,137	27,487,176	16,474,683	15,289,051	890,728	52,196	6,996,838	-	-	597,688	-	-
TOTAL CURRENT LIABILITIES	219,245,260	(2,477,857)	54,110,076	67,791,958	48,508,610	23,717,198	5,552,279	1,889,089	8,695,409	1,709,654	375,075	8,176,310	1,188,654	9,025
CONTSTRUCTION PAYABLE	1,429,678	-	-	1,173,595	164,600	89,483	-	-	-	-	-	-	-	-
LONG-TERM OBLIGATIONS, Net:														
Bonds payable	196,903,411	(964,999)	172,640,000	-	24,688,410	-	-	-	-	-	-	3,530,000	-	-
Notes payable	80,619,959	(338,210)	39,644,525	16,000,000	1,300,000	-	2,186,729	572,590	-	-	-	20,254,325	-	-
Capital lease obligation	22,231,317	-	10,054,479	7,051,413	4,676,092	135,911	-	-	313,422	-	-	-	-	-
Internal debt	-	934,999	(172,640,000)	107,505,121	34,298,422	24,250,865	5,630,593	-	-	-	-	-	-	-
DERIVATIVE FINANCIAL INSTRUMENTS	23,206,843	(1,066,220)	24,273,063	-	-	-	-	-	-	-	-	-	-	-
DEFERRED COMPENSATION	1,241,484	-	110	47,784	1,193,590	-	-	-	-	-	-	-	-	-
OTHER LIABILITIES	5,708,439	-	1,092,705	322,500	3,226,565	1,072,754	-	-	-	-	-	-	-	83,915
ESTIMATED SELF-INSURED PROFESSIONAL LIABILITY	7,146,732	-	7,146,732	-	-	-	-	-	-	-	-	-	-	-
TOTAL LIABILITIES	566,733,123	(3,882,287)	136,233,690	199,894,371	115,056,289	49,266,211	13,369,601	2,461,679	9,008,831	1,709,654	375,075	41,960,635	1,188,654	92,940
NET ASSETS:														
Unrestricted	229,314,759	-	75,374,492	59,772,597	(578,960)	54,639,595	10,679,807	741,884	13,987,685	2,532,461	(2,590,407)	11,559,040	1,389,556	1,601,009
Temporarily restricted	9,715,879	-	973,168	2,286,621	267,551	1,112,770	-	196,676	131,583	-	-	-	-	4,747,510
Permanently restricted	333,851	-	-	-	-	-	-	333,851	-	-	-	-	-	-
TOTAL NET ASSETS	239,368,489	-	76,347,660	62,059,218	(311,409)	55,752,365	10,679,807	1,272,411	14,119,268	2,532,461	(2,590,407)	11,559,040	1,389,556	6,348,519
TOTAL	$ 806,101,612	$ (3,882,287)	$ 212,599,350	$ 261,953,589	$ 114,744,880	$ 105,018,576	$ 24,249,408	$ 3,734,090	$ 23,128,099	$ 4,242,095	$ (2,215,332)	$ 53,519,675	$ 2,578,210	$ 6,441,459

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.

Schedule of Consolidating Information, Statement of Operations

For the Year Ended December 31, 2008

	Consolidated Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Laurie Center	Adventist Rehabilitation Hospital of Maryland	Adventist Home Health Services	Adventist Physician Services	Consolidated Adventist Senior Living Services	Consolidated Adventist Management Services, Inc.	SGAH, WAH, PRBH and HCH Foundations
UNRESTRICTED REVENUES														
Net patient service revenue	$ 774,014,846	$ (118,947)	$ 3,513,906	$ 290,676,095	$ 247,810,538	$ 90,987,904	$ 40,088,647	$ 262,342	$ 27,502,849	$ 13,857,151	$ 1,481,069	$ 57,953,292	$ -	$ -
Other revenue	40,425,837	(12,087,413)	6,396,847	5,620,635	5,494,354	2,275,498	13,818,375	5,955,922	210,278	21,730	46,340	1,581,148	8,096,281	2,995,842
TOTAL UNRESTRICTED REVENUES	814,440,683	(12,206,360)	9,910,753	296,296,730	253,304,892	93,263,402	53,907,022	6,218,264	27,713,127	13,878,881	1,527,409	59,534,440	8,096,281	2,995,842
EXPENSES														
Salaries and wages	334,836,121	-	14,862,247	102,075,452	88,980,933	37,852,294	31,633,634	3,311,956	14,147,626	8,873,067	2,793,588	27,466,021	2,839,303	-
Employee benefits	65,229,075	-	2,590,920	19,395,531	16,424,784	8,872,108	7,151,338	684,247	2,349,848	1,623,207	336,126	5,269,013	531,953	-
Contract labor	32,400,235	(3,854,599)	558,093	13,422,571	13,167,837	2,484,152	2,601,636	691,025	1,157,519	508,873	(77,106)	768,055	971,279	-
Medical supplies	119,372,823	(242,726)	(7,480)	48,648,327	46,998,551	10,557,355	2,719,918	33,307	1,739,076	216,188	12,711	6,765,905	1,931,691	-
General and administrative	114,109,674	(7,309,490)	37,191,838	31,040,214	28,065,070	7,081,748	2,544,916	1,063,147	2,290,194	738,294	319,621	6,887,362	1,187,838	3,008,922
Building and maintenance	42,250,054	(1,530,544)	826,210	19,950,504	8,786,911	5,506,883	3,830,112	579,111	935,913	590,786	174,654	2,245,949	353,565	-
Insurance	2,021,391	-	49,213	559,500	516,332	191,686	223,838	29,935	65,790	16,939	227,491	129,421	11,246	-
Provision for uncollectible accounts	43,302,605	-	36,392	13,617,572	19,829,489	6,057,794	1,052,913	66,148	471,162	99,185	-	1,993,480	78,470	-
Interest	14,526,306	-	947,012	5,881,249	3,276,433	1,824,751	368,269	16,811	339,416	-	-	1,872,365	-	-
Depreciation and Amortization	33,655,370	-	5,428,360	11,715,738	7,183,318	5,804,947	1,075,039	91,034	631,892	87,452	18,077	1,495,019	124,494	-
IT Depreciation	-	(10)	(6,475,335)	1,708,391	1,471,883	599,902	290,086	-	144,032	125,224	-	116,124	59,703	-
Allocation: IT Services	-	162,891	(32,351,995)	12,967,629	12,292,998	3,091,375	1,217,414	112,227	1,517,814	402,866	-	484,308	102,373	-
Allocation: Shared Services	-	(200)	-	-	200	-	-	-	-	-	-	-	-	-
AHC Management Fees	-	568,318	(23,570,824)	8,582,536	7,214,269	2,734,548	1,689,054	154,045	735,962	360,719	153,227	1,161,200	216,046	-
TOTAL EXPENSES	801,703,654	(12,206,360)	2,084,651	289,565,214	254,209,098	92,659,543	56,358,167	6,833,893	26,526,344	13,642,800	3,958,389	56,655,122	8,407,961	3,008,922
INCOME (LOSS) FROM OPERATIONS	12,737,029	-	7,826,102	6,731,516	(904,116)	603,859	(2,451,145)	(615,629)	1,186,783	236,081	(2,430,980)	2,879,318	(311,680)	(13,080)
OTHER INCOME (EXPENSE)														
Investment (loss) income	(21,052,090)	-	(6,660,573)	(4,297,904)	(1,533,814)	(4,339,368)	(1,252,516)	(42,050)	(415,486)	(271,459)	691	(2,053,301)	(52,730)	(133,580)
Other income (expense)	746,108	-	541,742	-	7,284	(330,081)	-	-	-	-	-	60,125	467,038	-
TOTAL OTHER (EXPENSE) INCOME	(20,305,982)	-	(6,118,831)	(4,297,904)	(1,526,530)	(4,669,449)	(1,252,516)	(42,050)	(415,486)	(271,459)	691	(1,993,176)	414,308	(133,580)
PORTION OF EARNINGS RELATED TO MINORITY INTEREST	(124,523)	-	-	-	-	-	-	-	-	-	-	-	(124,523)	-
REVENUES (LESS THAN) IN EXCESS OF EXPENSES	(7,693,476)	-	1,707,271	2,433,612	(2,430,646)	(4,065,590)	(3,703,661)	(657,679)	771,297	(35,378)	(2,430,289)	886,142	(21,895)	(146,660)
Change in unrealized gains and losses on investments other than trading securities	(11,489,990)	-	(6,252,837)	(1,788,758)	(613,120)	(1,477,112)	(281,578)	(25,088)	(344,169)	(64,630)	-	(355,163)	(330,268)	42,733
Change in unrealized loss on derivative financial instrument	(17,552,352)	-	(17,552,352)	-	-	-	-	-	-	-	-	-	-	-
Transfer to unconsolidated subsidiaries	(19,260)	-	736,472	(296,918)	(240,979)	-	(111,160)	(8,539)	(32,863)	(19,537)	(3,322)	-	(42,414)	-
Net assets released from restriction for purchase of property and equipment	2,325,529	-	17,547	1,827,669	447,813	-	-	32,500	-	-	-	-	-	-
Change in minority interest	(16,459)	-	-	-	-	-	-	-	-	-	-	-	(16,459)	-
Other unrestricted net assets activity	13,175	-	-	-	-	329,920	(316,745)	-	-	-	-	-	-	-
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	$ (34,432,833)	$ -	$ (21,343,899)	$ 2,175,605	$ (2,836,932)	$ (5,212,782)	$ (4,413,144)	$ (658,806)	$ 394,265	$ (119,545)	$ (2,433,611)	$ 530,979	$ (411,036)	$ (103,927)

ADVENTIST HEALTHCARE, INC.

Schedule of Consolidating Information, Statement of Changes in Net Assets

For the Year Ended December 31, 2008

	Consolidated Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Louise Center	Adventist Rehabilitation Hospital of Maryland	Adventist Home Health Services	Adventist Physician Services	Consolidated Adventist Senior Living Services	Consolidated Adventist Management Services, Inc.	SGAH, WAH, PRBH and HCH Foundations
UNRESTRICTED NET ASSETS:														
Revenues (less than) in excess of expenses	$ (7,695,476)	$ -	$ 1,707,271	$ 2,433,612	$ (2,430,646)	$ (4,065,590)	$ (3,703,561)	$ (657,679)	$ 771,297	$ (35,378)	$ (2,430,289)	$ 886,142	$ (21,895)	$ (146,660)
Change in unrealized gains and losses on investments other than trading securities	(11,489,999)	-	(6,252,837)	(1,788,758)	(613,120)	(1,477,112)	(281,578)	(25,088)	(344,169)	(64,630)	-	(355,163)	(330,268)	42,733
Change in unrealized loss on derivative financial instrument	(17,552,352)	-	(17,552,352)	-	-	-	-	-	-	-	-	-	-	-
Transfer to unconsolidated subsidiaries	(19,260)	-	736,472	(296,918)	(240,979)	-	(111,160)	(8,539)	(32,863)	(19,537)	(3,322)	-	(42,414)	-
Net assets released from restriction for purchase of property and equipment	2,325,529	-	17,547	1,827,669	447,813	-	-	32,500	-	-	-	-	-	-
Change in minority interest	(16,459)	-	-	-	-	-	-	-	-	-	-	-	(16,459)	-
Other unrestricted net assets activity	13,175	-	-	-	-	329,920	(316,745)	-	-	-	-	-	-	-
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	(34,432,833)	-	(21,343,899)	2,175,605	(2,836,932)	(5,212,782)	(4,413,144)	(658,806)	394,265	(119,545)	(2,433,611)	530,979	(411,036)	(103,927)
TEMPORARILY RESTRICTED NET ASSETS:														
Restricted gifts and donations	6,640,938	-	359,571	2,091,289	704,956	350,269	-	130,548	41,101	-	-	-	-	2,963,204
Net assets released from restriction for purchase of property and equipment	(2,325,529)	-	(17,547)	(1,827,669)	(447,813)	-	-	(32,500)	-	-	-	-	-	-
Net assets released from restriction for use in operations	(3,173,025)	-	(95,252)	(164,956)	(184,993)	-	-	(58,136)	(923)	-	-	-	-	(2,669,665)
Change in value of beneficial interest in trusts and charitable gift annuity obligation	(349,380)	-	(224,318)	-	-	-	-	-	-	-	-	-	-	(125,062)
Change in discount of pledges receivable and provision for doubtful pledges	(982,622)	-												(982,622)
Donor restricted investment income	(19,881)	-	-	-	-	-	-	-	-	-	-	-	-	(19,881)
(DECREASE) INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	(209,499)	-	22,454	99,564	72,150	350,269	-	39,912	40,178	-	-	-	-	(834,026)
PERMANENTLY RESTRICTED NET ASSETS,														
Permanently restricted gifts and donations	227,313	-	-	-	-	-	-	227,313	-	-	-	-	-	-
(DECREASE) INCREASE IN NET ASSETS	(34,415,019)	-	(21,321,445)	2,275,169	(2,764,782)	(4,862,513)	(4,413,144)	(391,581)	434,443	(119,545)	(2,433,611)	530,979	(411,036)	(937,953)
NET ASSETS, BEGINNING	273,783,508	-	97,688,105	59,784,049	2,453,373	60,614,878	15,292,951	1,663,992	13,684,825	2,642,006	(156,796)	11,028,061	1,800,592	7,286,472
NET ASSETS, ENDING	$ 239,368,489	$ -	$ 76,367,660	$ 62,059,218	$ (311,409)	$ 55,752,365	$ 10,879,807	$ 1,272,411	$ 14,119,268	$ 2,522,461	$ (2,590,407)	$ 11,559,040	$ 1,389,556	$ 6,348,519

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.
Schedule of Consolidating Information, Statement of Cash Flows
For the Year Ended December 31, 2008

	Consolidated Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Laurie Center	Adventist Rehabilitation Hospital of Maryland	Adventist Home Health Services	Adventist Physician Services	Consolidated Adventist Senior Living Services	Consolidated Adventist Management Services, Inc.	SGAH, WAH, PRBH and HCH Foundations
CASH FLOWS FROM OPERATING ACTIVITIES														
(Decrease) increase in net assets	$ (34,415,019)	$ -	(31,321,445)	2,275,169	(2,764,782)	(4,860,513)	(4,413,144)	$ (391,581)	$ 434,443	$ (119,545)	$ (2,433,611)	$ 530,979	$ (431,036)	$ (937,953)
Adjustments to reconcile (decrease) increase in net assets to cash provided by (used in) operating activities:				o										
Provision for uncollectible accounts	45,302,605	-	36,392	13,617,572	19,829,489	6,057,794	1,052,913	66,148	471,162	99,185	-	1,993,480	78,470	-
Depreciation and amortization	35,655,370	-	5,428,360	11,715,738	7,183,318	5,804,947	1,075,059	91,034	631,892	87,452	18,077	1,495,039	124,494	-
Gain on sale of property and equipment	(5,097)	-	-	-	-	(5,097)	-	-	-	-	-	-	-	-
Restricted contributions and grants	(6,245,841)	-	(359,571)	(2,091,289)	(704,956)	(826,107)	-	(357,861)	(41,101)	-	-	-	-	(1,864,956)
Net organization transfer among affiliates	-	-	-	-	(37,578)	-	-	-	-	-	-	-	37,578	-
Earnings from investments and investments in unconsolidated subsidiaries	(3,593,807)	-	(3,004,224)	(478,078)	-	-	-	-	-	-	-	(111,505)	-	-
Amortization of bond discounts	9,790	-	-	-	9,790	-	-	-	-	-	-	-	-	-
Amortization of physician income guarantees	481,506	-	-	155,883	325,623	-	-	-	-	-	-	-	-	-
Cash transfers among affiliates	-	(2,682,445)	-	-	-	-	-	-	-	-	-	-	-	2,682,445
Change in unrealized losses (gains) on investments other than trading securities	11,592,402	5,184,756	6,252,837	(6,426)	(57,726)	-	(3,654)	-	-	-	-	269,639	-	(36,014)
Change in fair value of charitable remainder trusts and obligation to annuitants	349,389	-	224,318	-	-	-	-	-	-	-	-	-	-	125,062
Change in net unrealized loss on derivative financial instruments	18,695,514	-	18,695,514	-	-	-	-	-	-	-	-	-	-	-
Change in discount on pledges receivable and provision for doubtful pledges	(104,895)	-	-	-	-	-	-	-	-	-	-	-	-	(104,895)
Changes in assets and liabilities:														
Patient accounts receivable, net	(49,815,270)	-	55,783	(19,067,895)	(20,362,675)	(7,671,148)	91,851	-	(1,997,060)	(92,552)	455,016	(1,243,908)	17,318	-
Other receivables, net	5,822,548	944,614	2,548,740	(30,458)	(1,060,321)	(172,517)	(965,735)	(24,530)	(67,968)	(93,096)	(39,094)	96,564	(56,870)	735,619
Inventories, prepaid expenses and other current assets	(565,105)	-	(512,529)	384,906	167,730	(447,423)	(6,571)	(624)	(39,385)	(12,618)	(3,799)	(49,147)	(67,838)	23,093
Accounts payable and accrued expenses	(2,754,691)	(944,614)	1,824,982	(3,982,924)	(1,895,378)	1,199,255	449,408	536,615	(443,808)	21,725	(21,073)	345,057	(839,754)	(272)
Accrued compensation and related expenses	4,746,933	-	1,315,821	1,742,465	637,945	(297,608)	378,650	49,042	284,536	139,287	142,798	413,649	(59,652)	
Interest payable	(925,788)	-	(327,711)	-	-	-	-	-	-	-	-	3,923	-	
Estimated self-insured professional liability	2,634,705	-	2,634,705	-	-	-	-	-	-	-	-	-	-	
Due to third party payors	2,798,872	-	-	(171,697)	393,270	769,851	829,690	-	(34,088)	-	-	1,011,846	-	
Other noncurrent assets and liabilities	865,055	-	730,470	566,178	107,687	(630,035)	92,850	-	(92,000)	-	-	(3,315)	32,063	457
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	23,131,169	2,502,311	15,222,442	4,628,244	1,771,428	(1,080,681)	(1,424,623)	(31,757)	(833,377)	29,838	(1,872,686)	4,743,081	(1,142,527)	620,186
CASH FLOWS FROM INVESTING ACTIVITIES														
Purchase of property and equipment	(51,955,097)	199,114	(4,995,282)	(35,847,059)	(4,782,980)	(3,012,586)	(452,327)	(8,060)	(270,188)	(155,896)	(48,723)	(3,304,874)	(76,236)	-
Payments to physicians under income guarantees	(100,224)	-	-	(69,477)	(30,751)	-	-	-	-	-	-	-	-	-
Decrease (increase) in investments and investments in unconsolidated subsidiaries	(2,218,620)	(5,184,756)	2,541,829	-	-	-	-	-	-	-	-	-	-	424,307
Net additions to land held for healthcare development	(8,489,978)	-	(1,294,523)	-	(6,195,455)	-	-	-	-	-	-	-	-	-
Proceeds from the sale of property and equipment	5,097	(199,114)	-	-	-	5,097	-	-	-	-	-	-	199,114	-
Distribution from investments in unconsolidated subsidiaries	5,055,768	-	4,553,649	502,119	-	-	-	-	-	-	-	-	-	-
Cash transfers among affiliates	-	2,682,445	-	-	-	-	-	-	-	-	-	-	-	(2,682,445)
(Increase) decrease in trustee held funds / restricted cash	(7,460,217)	-	2,932,637	(5,583,810)	(3,613,893)	(390,435)	(477)	(268,335)	(417,301)	-	-	(128,511)	-	9,108
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(65,163,275)	(2,502,311)	2,738,310	(40,197,427)	(14,623,079)	(3,397,924)	(452,804)	(276,395)	(687,489)	(155,896)	(48,723)	(3,433,385)	122,878	(2,249,030)
CASH FLOWS FROM FINANCING ACTIVITIES														
Payments of financing costs	(122,122)	-	-	(17,460)	(10,184)	-	-	-	(1,455)	-	-	(93,023)	-	-
Repayments of long-term obligations, net	(15,487,983)	-	(7,338,959)	(2,253,219)	(1,490,715)	(2,585,316)	(329,850)	(40,409)	(983,031)	-	-	(557,484)	-	-
Proceeds from issuance of long-term obligations, net	55,175,000	-	10,005,000	20,800,000	2,800,000	-	-	-	400,000	-	-	1,170,000	-	-
Transfer of debt among affiliates	-	-	(2,155,787)	1,275,787	880,000	-	-	-	-	-	-	-	-	-
Proceeds from short-term financing	20,000,000	-	20,000,000	-	-	-	-	-	-	-	-	-	-	-
Proceeds from restricted contributions and grants	6,245,841	-	359,571	2,091,289	704,956	826,107	-	357,861	41,101	-	-	-	-	1,864,956
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	45,810,736	-	20,869,825	21,896,397	2,884,057	(1,759,209)	(329,850)	308,452	(543,385)	-	-	519,493	-	1,864,956
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	3,778,630	-	38,830,577	(13,672,786)	(9,967,584)	(6,237,734)	(2,207,277)	300	(2,064,251)	(126,058)	(1,921,409)	1,829,189	(1,020,649)	236,112
CASH AND CASH EQUIVALENTS, BEGINNING	11,893,028	-	(9,235,193)	30,116,270	21,390,375	35,490,926	2,520,211	1,150	6,157,492	1,866,450	(1,437,905)	12,725,302	933,850	1,364,098
CASH AND CASH EQUIVALENTS, ENDING	$ 15,671,658	$ -	$ 29,595,384	$ 16,443,484	$ 11,422,791	$ 29,253,192	$ 312,934	$ 1,450	$ 4,093,241	$ 1,740,392	$ (3,359,314)	$ 14,554,491	$ (86,799)	$ 1,600,210

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC. - Obligated Group
Schedule of Combining Information, Balance Sheet
December 31, 2008

	Combined AHC Obligated Group	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Community Hospital	Potomac Ridge	Adventist Rehabilitation Hospital of Maryland
ASSETS								
Current assets:								
Cash and cash equivalents	$ 1,221,028	$ -	$ (60,404,614)	$ 16,443,484	$ 11,422,791	$ 29,253,192	$ 412,934	$ 4,093,241
Short-term investments	139,716,446	-	139,716,446	-	-	-	-	-
Assets whose use is limited	8,722,000	-	6,958,853	-	1,763,147	-	-	-
Patient accounts receivable, net of estimated allowances of $59,465,000	104,142,384	-	168,815	41,939,609	38,304,690	11,113,917	5,320,812	7,294,541
Other receivables, net of estimated allowance for uncollectible accounts of $887,000	8,075,351	-	388,080	1,616,704	1,758,204	391,393	3,818,938	102,032
Due from third party payors	-	(463,781)	-	-	-	-	-	463,781
Inventories	10,530,334	-	-	4,568,777	3,468,513	2,279,736	129,013	84,295
Prepaid expenses and other current assets	3,323,388	-	1,992,469	271,722	374,801	450,296	148,838	85,262
TOTAL CURRENT ASSETS	275,730,931	(463,781)	88,820,049	64,840,296	57,092,146	43,488,534	9,830,535	12,123,152
PROPERTY AND EQUIPMENT, Net	357,064,308	-	56,849,554	185,123,745	41,949,436	52,672,801	11,208,400	9,260,372
ASSETS WHOSE USE IS LIMITED:								
Under trust indentures, held by trustee	15,908,659	-	3,475,784	5,230,735	5,321,295	1,195,498	286,582	398,765
Professional liability trust fund	6,188,516	-	6,188,516	-	-	-	-	-
Deferred compensation fund	1,241,374	-	-	47,784	1,193,590	-	-	-
CASH AND CASH EQUIVALENTS TEMPORARILY RESTRICTED FOR CAPITAL ACQUISITION	1,781,372	-	-	533,717	-	1,161,096	-	86,559
INVESTMENTS AND INVESTMENTS IN UNCONSOLIDATED SUBISIDIARIES	9,676,244	-	6,323,492	1,174,045	-	2,150,505	28,202	-
LAND HELD FOR HEALTHCARE DEVELOPMENT	55,813,484	-	48,203,267	-	7,610,217	-	-	-
DEFERRED FINANCING COSTS, Net	3,095,788	-	121,209	1,310,806	955,782	519,495	96,626	91,870
INTANGIBLE ASSETS, Net	7,595,206	-	99,752	3,178,478	60,133	699,283	2,422,179	1,135,381
DERIVATIVE FINANCIAL INSTRUMENTS	-	(1,066,220)	1,066,220	-	-	-	-	-
DEPOSITS AND OTHER NONCURRENT ASSETS	6,068,019	-	1,451,507	513,983	562,281	3,131,364	376,884	32,000
TOTAL	$ 740,163,901	$ (1,530,001)	$ 212,599,350	$ 261,953,589	$ 114,744,880	$ 105,018,576	$ 24,249,408	$ 23,128,099

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC. - Obligated Group
Schedule of Combining Information, Balance Sheet
December 31, 2008

	Combined AHC Obligated Group	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Community Hospital	Potomac Ridge	Adventist Rehabilitation Hospital of Maryland
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES:								
Accounts payable and accrued expenses	$ 59,617,242	$ -	$ 13,680,198	$ 21,146,655	$ 17,089,389	$ 5,204,762	$ 1,978,906	$ 517,332
Accrued compensation and related items	29,662,659	-	4,821,098	9,725,042	8,220,389	3,072,350	2,642,541	1,181,239
Interest payable	1,135,835	-	1,135,835	-	-	-	-	-
Due to third party payors	15,884,592	(463,781)	-	9,433,085	6,724,149	151,035	40,104	-
Estimated self-insured professional liability	1,185,808		1,185,808	-	-	-	-	-
Short-term financing	20,000,000	-	20,000,000	-	-	-	-	-
Current maturities of long-term obligations	80,425,613	-	13,287,137	27,487,176	16,474,683	15,289,051	890,728	6,996,838
TOTAL CURRENT LIABILITIES	207,911,749	(463,781)	54,110,076	67,791,958	48,508,610	23,717,198	5,552,279	8,695,409
CONTSTRUCTION PAYABLE	1,429,678	-	-	1,175,595	164,600	89,483	-	-
LONG-TERM OBLIGATIONS, Net								
Bonds payable	193,373,411	(954,999)	172,640,000	-	21,688,410	-	-	-
Notes payable	59,131,254	-	39,644,525	16,000,000	1,300,000	-	2,186,729	-
Capital lease obligation	22,231,317	-	10,054,479	7,051,413	4,676,092	135,911	-	313,422
Internal debt	-	954,999	(172,640,000)	107,505,121	34,298,422	24,250,865	5,630,593	-
DERIVATIVE FINANCIAL INSTRUMENTS	23,206,843	(1,066,220)	24,273,063	-	-	-	-	-
DEFERRED COMPENSATION	1,241,484	-	110	47,784	1,193,590	-	-	-
OTHER LIABILITIES	5,624,524	-	1,002,705	322,500	3,226,565	1,072,754	-	-
ESTIMATED SELF INSURED PROFESSIONAL LIABILITY	7,146,732	-	7,146,732	-	-	-	-	-
TOTAL LIABILITIES	521,296,992	(1,530,001)	136,231,690	199,894,371	115,056,289	49,266,211	13,369,601	9,008,831
NET ASSETS:								
Unrestricted	214,095,216	-	75,394,492	59,772,597	(578,960)	54,639,595	10,879,807	13,987,685
Temporarily restricted	4,771,693	-	973,168	2,286,621	267,551	1,112,770	-	131,583
TOTAL NET ASSETS	218,866,909	-	76,367,660	62,059,218	(311,409)	55,752,365	10,879,807	14,119,268
TOTAL	$ 740,163,901	$ (1,530,001)	$ 212,599,350	$ 261,953,589	$ 114,744,880	$ 105,018,576	$ 24,249,408	$ 23,128,099

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC. - Obligated Group

Schedule of Combining Information, Statement of Operations

For the Year Ended December 31, 2008

	Combined AHC Obligated Group	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Community Hospital	Potomac Ridge	Adventist Rehabilitation Hospital of Maryland
UNRESTRICTED REVENUES								
Net patient service revenue	$ 700,579,939	$ -	$ 3,513,906	$ 290,676,095	$ 247,810,538	$ 90,987,904	$ 40,088,647	$ 27,502,849
Other revenue	27,490,943	(6,325,044)	6,396,847	5,620,635	5,494,354	2,275,498	13,818,375	210,278
TOTAL UNRESTRICTED REVENUES	728,070,882	(6,325,044)	9,910,753	296,296,730	253,304,892	93,263,402	53,907,022	27,713,127
EXPENSES								
Salaries and wages	289,552,186	-	14,862,247	102,075,452	88,980,933	37,852,294	31,633,634	14,147,626
Employee benefits	56,784,529	-	2,590,920	19,395,531	16,424,784	8,872,108	7,151,338	2,349,848
Contract labor	29,689,255	(3,702,553)	558,093	13,422,571	13,167,837	2,484,152	2,601,636	1,157,519
Medical supplies	110,413,021	(242,726)	(7,480)	48,648,327	46,998,551	10,557,355	2,719,918	1,739,076
General and administrative	107,364,759	(849,221)	37,191,838	31,040,214	28,065,070	7,081,748	2,544,916	2,290,194
Building and maintenance	38,305,989	(1,530,544)	826,210	19,950,504	8,786,911	5,506,883	3,830,112	935,913
Insurance	1,606,359	-	49,213	559,500	516,332	191,686	223,838	65,790
Provision for uncollectible accounts	41,065,322	-	36,392	13,617,572	19,829,489	6,057,794	1,052,913	471,162
Interest	12,637,130	-	947,012	5,881,249	3,276,433	1,824,751	368,269	339,416
Depreciation and amortization	31,839,294	-	5,428,360	11,715,738	7,183,318	5,804,947	1,075,039	631,892
IT Depreciation	(301,041)	-	(4,475,335)	1,708,391	1,471,883	599,902	250,086	144,032
Allocation: Corp Services	(1,264,665)	-	(32,351,995)	12,967,629	12,292,998	3,091,375	1,217,414	1,517,914
Allocation: Shared Services MD	200	-	-	-	200	-	-	-
IT Services Allocation	(2,614,455)	-	(23,570,824)	8,582,536	7,214,269	2,734,548	1,689,054	735,962
TOTAL EXPENSES	715,077,883	(6,325,044)	2,084,651	289,565,214	254,209,008	92,659,543	56,358,167	26,526,344
INCOME (LOSS) FROM OPERATIONS	12,992,999	-	7,826,102	6,731,516	(904,116)	603,859	(2,451,145)	1,186,783
OTHER INCOME (EXPENSE)								
Investment loss	(18,499,661)	-	(6,660,573)	(4,297,904)	(1,533,814)	(4,339,368)	(1,252,516)	(415,486)
Other income (expense)	218,945	-	541,742	-	7,284	(330,081)	-	-
TOTAL OTHER EXPENSE	(18,280,716)	-	(6,118,831)	(4,297,904)	(1,526,530)	(4,669,449)	(1,252,516)	(415,486)
REVENUES (LESS THAN) IN EXCESS OF EXPENSES	(5,287,717)	-	1,707,271	2,433,612	(2,430,646)	(4,065,590)	(3,703,661)	771,297
Change in unrealized gains and losses on investments other than trading securities	(10,757,574)	-	(6,252,837)	(1,788,758)	(613,120)	(1,477,112)	(281,578)	(344,169)
Change in unrealized loss on derivative financial instrument	(17,552,352)	-	(17,552,352)	-	-	-	-	-
Transfer to unconsolidated subsidiaries	54,552	-	736,472	(296,918)	(240,979)	-	(111,160)	(32,863)
Net assets released from restriction for purchase of property and equipment	2,293,029	-	17,547	1,827,669	447,813	-	-	-
Other unrestricted net assets activity	13,175	-	-	-	-	329,920	(316,745)	-
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	$ (31,236,887)	$ -	$ (21,343,899)	$ 2,175,605	$ (2,836,932)	$ (5,212,782)	$ (4,413,144)	$ 394,265

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.
Obligated Group
Schedule of Combining Information, Statement of Cash Flows
For the Year Ended December 31, 2008

	Combined Adventist HealthCare, Inc.	Eliminating Entries	Support Center	Shady Grove Adventist Hospital	Washington Adventist Hospital	Hackettstown Regional Medical Center	Potomac Ridge	Adventist Rehabilitation Hospital of Maryland
CASH FLOWS FROM OPERATING ACTIVITIES								
(Decrease) increase in net assets	$ (30,652,272)	$ -	$ (21,321,445)	$ 2,275,169	$ (2,764,782)	$ (4,862,513)	$ (4,413,144)	$ 434,443
Adjustments to reconcile (decrease) increase in net assets to cash provided by (used in) operating activities:								
Depreciation and amortization	31,839,294	-	5,428,360	11,715,738	7,183,318	5,804,947	1,075,039	631,892
Provision for uncollectible accounts	41,065,322	-	36,392	13,617,572	19,829,489	6,057,794	1,052,913	471,162
Gain on sale of property and equipment	(5,097)	-	-	-	-	(5,097)	-	-
Restricted contributions and grants	(4,023,024)	-	(359,571)	(2,091,289)	(704,956)	(826,107)	-	(41,101)
Net organization transfer among affiliates	(37,578)		-	-	(37,578)	-	-	-
Earnings from investments and investments in unconsolidated subsidiaries	(3,482,302)	-	(3,004,224)	(478,078)	-	-	-	-
Amortization of bond discounts	9,790	-	-	-	9,790	-	-	-
Amortization of physician income guarantees	481,508		-	155,883	325,625	-	-	-
Noncash transfers to (from) affiliates	-	-	-	-	-	-	-	-
Cash transfers among affiliates	-	-	-	-	-	-	-	-
Change in unrealized losses (gains) on investments other than trading securities	11,367,777	5,184,756	6,252,837	(6,426)	(57,726)	-	(5,664)	-
Change in fair value of charitable remainder trusts and obligation to annuitants	224,318	-	224,318	-	-	-	-	-
Change in net unrealized gain on derivative financial instruments	18,695,514	-	18,695,514	-	-	-	-	-
Changes in assets and liabilities:								
Patient accounts receivable, net	(48,951,144)	-	55,783	(19,067,895)	(20,362,675)	(7,671,148)	91,851	(1,997,060)
Other receivables, net	251,741	-	2,548,740	(30,458)	(1,060,321)	(172,517)	(965,735)	(67,968)
Inventories, prepaid expenses and other current assets	(454,172)	-	(512,529)	384,006	167,730	(447,423)	(6,571)	(39,385)
Accounts payable and accrued expenses	(1,852,375)	-	2,824,982	(3,982,924)	(1,895,378)	1,199,255	445,498	(443,808)
Accrued compensation and related expenses	4,061,809	-	1,315,821	1,742,465	637,945	(297,608)	378,650	284,536
Interest payable	(327,711)	-	(327,711)	-	-	-	-	-
Estimated self-insured professional liability	2,634,705	-	2,634,705	-	-	-	-	-
Due to third party payors	1,787,026	-	-	(171,697)	393,270	769,851	829,690	(34,088)
Other noncurrent assets and liabilities	835,150	-	730,470	566,178	107,687	(630,035)	92,850	(32,000)
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	23,468,279	5,184,756	15,222,442	4,628,244	1,771,438	(1,080,601)	(1,424,623)	(833,377)
CASH FLOWS FROM INVESTING ACTIVITIES								
Purchase of property and equipment	(48,560,422)	-	(4,995,282)	(35,047,059)	(4,782,980)	(3,012,586)	(452,327)	(270,188)
Payments to physicians under income guarantees	(100,228)	-	-	(69,477)	(30,751)	-	-	-
Decrease (increase) in investments (including investments in unconsolidated subsidiaries)	(2,642,927)	(5,184,756)	2,541,829	-	-	-	-	-
Net additions to land held for healthcare development	(8,489,978)	-	(2,294,523)	-	(6,195,455)	-	-	-
Proceeds from the sale of property and equipment	5,097	-	-	-	-	5,097	-	-
Receipt of distribution from unconsolidated subsidiaries	5,055,768	-	4,553,649	502,119	-	-	-	-
(Increase) decrease in trustee held funds / restricted cash	(7,072,479)	-	2,932,637	(5,583,010)	(3,613,893)	(390,435)	(477)	(417,301)
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(61,805,169)	(5,184,756)	2,738,310	(40,197,427)	(14,623,079)	(3,397,924)	(452,804)	(687,489)
CASH FLOWS FROM FINANCING ACTIVITIES								
Payments of financing costs	(29,099)	-	-	(17,460)	(10,184)	-	-	(1,455)
Repayments of long-term obligations, net	(14,881,090)	-	(7,338,959)	(2,253,219)	(1,490,715)	(2,585,316)	(229,850)	(983,031)
Proceeds from issuance of long-term obligations, net	34,005,000	-	10,005,000	20,800,000	2,800,000	-	-	400,000
Transfer of debt among affiliates	-		(2,155,787)	1,275,787	880,000	-	-	-
Short-term financing	20,000,000	-	20,000,000	-	-	-	-	-
Proceeds from restricted contributions and grants	4,023,024	-	359,571	2,091,289	704,956	826,107	-	41,101
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	43,117,835	-	20,869,825	21,896,397	2,884,057	(1,759,209)	(229,850)	(543,385)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	4,780,945	-	38,830,577	(13,672,786)	(9,967,584)	(6,237,734)	(2,107,277)	(2,064,251)
CASH AND CASH EQUIVALENTS, BEGINNING	(3,559,917)	-	(99,235,191)	30,116,270	21,390,375	35,490,926	2,520,211	6,157,492
CASH AND CASH EQUIVALENTS, ENDING	$ 1,221,028	$ -	$ (60,404,614)	$ 16,443,484	$ 11,422,791	$ 29,253,192	$ 412,934	$ 4,093,241

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.

Adventist Senior Living Services

Schedule of Consolidating Information, Balance Sheet

December 31, 2008

ASSETS	Consolidated Adventist Senior Living Services	Eliminating Entries	Adventist Senior Living Services	Sligo Creek Adventist Nursing & Rehab Center, Inc.	Shady Grove Adventist Nursing & Rehab Center, Inc.	Bradford Oaks Adventist Nursing & Rehab Center, Inc.	Springbrook Adventist Nursing & Rehab Center, Inc.	Fairland Adventist Nursing & Rehab Center, Inc.	Adventist Dialysis Services
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 14,554,491	$ -	$ (513,306)	$ 3,691,811	$ 3,464,724	$ 4,764,999	$ 1,850,005	$ 681,026	$ 615,232
Assets whose use is limited	98,090	-	-	-	-	-	98,090	-	-
Patient accounts receivable, net of estimated allowances of $3,065,000	8,536,150	-	30	1,313,401	1,680,232	2,860,446	1,035,892	1,562,222	83,927
Due from third party payors	-	(192,680)	-	-	192,680	-	-	-	-
Other receivables	13,528	-	-	3,449	2,914	4,336	1,703	577	549
Inventories	32,954	-	-	-	-	-	-	-	32,954
Prepaid expenses and other current assets	123,613	-	-	8,787	48,481	47,696	14,935	3,089	625
TOTAL CURRENT ASSETS	23,358,826	(192,680)	(513,276)	5,017,448	5,389,031	7,677,477	3,000,625	2,246,914	733,287
PROPERTY AND EQUIPMENT, Net	25,844,460	-	33,466	4,213,145	5,936,087	8,956,273	2,827,415	3,360,134	517,940
ASSETS WHOSE USE IS LIMITED UNDER TRUST INDENTURES, HELD BY TRUSTEES	2,287,624	-	-	763,003	617,403	449,743	457,475	-	-
INVESTMENTS AND INVESTMENTS IN UNCONSOLIDATED SUBSIDIARIES	718,188	-	718,188	-	-	-	-	-	-
DEFERRED FINANCING COSTS, Net	1,301,312	-	-	226,730	382,600	540,886	151,096	-	-
DEPOSITS AND OTHER NONCURRENT ASSETS	9,065	-	9,065	-	-	-	-	-	-
TOTAL	$ 53,519,475	$ (192,680)	$ 247,443	$ 10,220,326	$ 12,325,121	$ 17,624,379	$ 6,436,611	$ 5,607,048	$ 1,251,227

ADVENTIST HEALTHCARE, INC.
Adventist Senior Living Services
Schedule of Consolidating Information, Balance Sheet
December 31, 2008

LIABILITIES AND NET ASSETS	Consolidated Adventist Senior Living Services	Eliminating Entries	Adventist Senior Living Services	Sligo Creek Adventist Nursing & Rehab Center, Inc.	Shady Grove Adventist Nursing & Rehab Center, Inc.	Bradford Oaks Adventist Nursing & Rehab Center, Inc.	Springbrook Adventist Nursing & Rehab Center, Inc.	Fairland Adventist Nursing & Rehab Center, Inc.	Adventist Dialysis Services
CURRENT LIABILITIES:									
Accounts payable and accrued expenses	$ 4,305,646	$ -	$ 133,167	$ 774,359	$ 887,210	$ 933,414	$ 490,048	$ 766,177	$ 321,271
Accrued compensation and related items	2,445,139	-	209,572	371,565	536,679	649,622	289,623	388,078	-
Interest payable	130,361	-	-	25,488	45,889	58,984	-	-	-
Due to third party payors	697,276	(192,680)	-	377,024	-	10,351	478,666	23,915	-
Current maturities of long-term obligations	597,688	-	-	87,002	154,349	201,337	155,000	-	-
TOTAL CURRENT LIABILITIES	8,176,110	(192,680)	342,739	1,635,438	1,624,127	1,853,708	1,413,337	1,178,170	321,271
LONG-TERM OBLIGATIONS, Net:									
Bonds payable	3,530,000	-	-	-	-	-	3,530,000	-	-
Notes payable	30,254,325	-	-	5,525,105	9,843,251	12,785,969	-	2,100,000	-
TOTAL LIABILITIES	41,960,435	(192,680)	342,739	7,160,543	11,467,378	14,639,677	4,943,337	3,278,170	321,271
UNRESTRICTED NET ASSETS	11,559,040	-	(95,296)	3,059,783	857,743	2,984,702	1,493,274	2,328,878	929,956
TOTAL	$ 53,519,475	$ (192,680)	$ 247,443	$ 10,220,326	$ 12,325,121	$ 17,624,379	$ 6,436,611	$ 5,607,048	$ 1,251,227

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.

Adventist Senior Living Services

Schedule of Consolidating Information, Statement of Operations

December 31, 2008

	Consolidated Adventist Senior Living Services	Eliminating Entries	Adventist Senior Living Services	Sligo Creek Adventist Nursing & Rehab Center, Inc.	Shady Grove Adventist Nursing & Rehab Center, Inc.	Bradford Oaks Adventist Nursing & Rehab Center, Inc.	Springbrook Adventist Nursing & Rehab Center, Inc.	Fairland Adventist Nursing & Rehab Center, Inc.	Adventist Dialysis Services
UNRESTRICTED REVNUES									
Net patient service revenue	$ 57,953,292	$ -	$ -	$ 9,234,388	$ 13,123,589	$ 15,349,900	$ 7,740,259	$ 9,983,953	$ 2,521,203
Other revenue	1,581,148	(51,390)	970,466	3,928	20,256	41,421	54,642	541,825	-
TOTAL UNRESTRICTED REVENUES	59,534,440	(51,390)	970,466	9,238,316	13,143,845	15,391,321	7,794,901	10,525,778	2,521,203
EXPENSES									
Salaries and wages	27,466,021	-	2,637,732	3,796,020	5,848,849	7,186,537	3,530,916	4,465,967	-
Employee benefits	5,269,013	-	536,515	686,079	1,158,920	1,420,610	635,202	831,687	-
Contract labor	768,955	-	14,377	21,122	576,313	21,113	35,275	66,380	34,375
Medical supplies	6,765,905	-	-	947,180	1,637,469	1,344,790	811,572	1,471,339	553,555
General and administrative	6,887,362	-	383,026	1,086,500	695,910	1,453,160	764,214	1,635,980	868,572
Building and maintenance	2,245,949	(51,390)	179,495	255,482	616,246	502,130	321,806	357,308	64,872
Insurance	129,421	-	3,741	18,565	51,790	28,053	9,922	16,530	820
Provision for uncollectible accounts	1,993,480	-	-	349,299	83,236	844,432	53,855	473,568	189,090
Interest	1,872,365	-	-	241,603	581,826	826,612	146,809	75,515	-
Depreciation and Amortization	1,495,019	-	5,320	257,203	301,885	457,436	237,995	191,052	44,128
IT Depreciation	116,124	-	18,790	12,674	38,027	23,995	12,224	10,414	-
Allocation: IT Services	484,308	-	89,216	63,022	129,102	66,637	64,686	71,645	-
Allocation: Shared Services	-	-	-	-	-	-	-	-	-
AHC Management Fees	1,161,200	-	(2,063,121)	503,948	663,689	742,942	503,117	646,747	163,878
EXPENSES	56,655,122	(51,390)	1,805,091	8,238,697	12,383,262	14,918,447	7,127,593	10,314,132	1,919,290
INCOME (LOSS) FROM OPERATIONS	2,879,318	-	(834,625)	999,619	760,583	472,874	667,308	211,646	601,913
OTHER INCOME (LOSS)									
Investment loss	(2,053,301)	-	17,059	(529,824)	(474,305)	(720,094)	(248,357)	(40,486)	(57,294)
Other income	60,125	-	60,125	-	-	-	-	-	-
TOTAL OTHER (LOSS) INCOME	(1,993,176)	-	77,184	(529,824)	(474,305)	(720,094)	(248,357)	(40,486)	(57,294)
REVENUES IN EXCESS OF (LESS THAN) EXPENSES	886,142	-	(757,441)	469,795	286,278	(247,220)	418,951	171,160	544,619
Change in unrealized gains and losses on investments other than trading securities	(355,163)	-	(25,235)	(95,542)	(93,337)	(80,360)	(21,686)	(39,003)	-
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	$ 530,979	$ -	$ (782,676)	$ 374,253	$ 192,941	$ (327,580)	$ 397,265	$ 132,157	$ 544,619

See Notes to Consolidated Financial Statements

ADVENTIST HEALTHCARE, INC.
ADVENTIST SENIOR LIVING SERVICES
Schedule of Consolidating Information, Statement of Cash Flows
For the Year Ended December 31, 2008

	Combined Adventist Senior Living Services	Eliminating Entries	Adventist Senior Living	Sligo Creek Adventist Nursing & Rehabilitation Center, Inc.	Shady Grove Adventist Nursing & Rehabilitation Center, Inc.	Bradford Oaks Adventist Nursing & Rehabilitation Center, Inc.	Springbrook Adventist Nursing & Rehabilitation Center, Inc.	Fairland Adventist Nursing & Rehabilitation Center, Inc.	Dialysis
CASH FLOWS FROM OPERATING ACTIVITIES									
Increase (decrease) in net assets	$ 530,979	-	$ (782,676)	$ 374,253	$ 192,941	$ (327,580)	$ 397,265	$ 132,157	$ 544,619
Adjustments to reconcile increase (decrease) in net assets to cash provided by operating activities:									
Depreciation and amortization	1,495,019	-	5,320	257,203	301,885	457,436	237,995	191,052	44,128
Provision for uncollectible accounts	1,993,480	-	-	349,299	83,236	844,432	53,855	473,568	189,090
Change in unrealized losses (gains) on other than trading securities	260,639	-	-	95,542	93,337	80,360	(8,600)	-	-
Earnings from investments and investments in unconsolidated affiliates	(111,505)	-	(111,505)	-	-	-	-	-	-
Changes in assets and liabilities:									
Patient accounts receivable, net	(1,243,908)	-	(30)	(144,986)	(313,491)	(295,971)	(301,498)	(136,815)	(51,117)
Other receivables, net	96,564	-	78,792	17,774	622	266	(87)	(254)	(549)
Inventories, prepaid expenses and other current assets	(49,147)	-	622	(980)	(30,291)	(17,208)	(5,374)	4,709	(625)
Accounts payable and accrued expenses	345,057	-	(39,953)	100,213	41,913	40,540	56,698	126,509	19,137
Accrued compensation and related expenses	413,649	-	31,896	49,378	101,757	118,835	44,464	67,119	-
Interest payable	3,923	-	-	(375)	5,164	(866)	-	-	-
Due to third party payors	1,011,846	-	-	292,603	131,863	273,301	234,858	79,221	-
Other noncurrent assets and liabilities	(3,515)	-	(9,065)	-	-	-	-	5,550	-
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	4,743,081	-	(826,599)	1,390,124	608,936	1,173,545	709,576	942,816	744,683
CASH FLOWS FROM INVESTING ACTIVITIES									
Purchases of property and equipment	(3,304,874)	-	(27,391)	(1,178,923)	(1,162,821)	(377,272)	(265,542)	(252,288)	(40,637)
Net decrease (increase) in trustee-held funds	(128,511)	-	-	319,863	(347,997)	(91,521)	(8,856)	-	-
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(3,433,385)	-	(27,391)	(859,060)	(1,510,818)	(468,793)	(274,398)	(252,288)	(40,637)
CASH FLOWS FROM FINANCING ACTIVITIES									
Proceeds from the issuance of long-term obligations	1,170,000	-	-	-	1,170,000	-	-	-	-
Payments of deferred financing costs	(93,023)	-	-	-	(93,023)	-	-	-	-
Repayments of long-term obligations, net	(557,484)	-	-	(82,399)	(139,404)	(190,681)	(145,000)	-	-
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	519,493	-	-	(82,399)	937,573	(190,681)	(145,000)	-	-
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	1,829,189	-	(853,990)	448,665	35,691	514,071	290,178	690,528	704,046
CASH AND CASH EQUIVALENTS, BEGINNING	12,725,302	-	340,684	3,243,146	3,429,033	4,250,928	1,559,827	(9,502)	(88,814)
CASH AND CASH EQUIVALENTS, ENDING	$ 14,554,491	$ -	$ (513,306)	$ 3,691,811	$ 3,464,724	$ 4,764,999	$ 1,850,005	$ 681,026	$ 615,232

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.

Foundations

Schedule of Combining Information, Balance Sheet
December 31, 2008

	Combined Adventist HealthCare, Inc. Foundations	Eliminating Entries	Shady Grove Adventist Hospital Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Hackettstown Community Hospital Foundation, Inc.	Potomac Ridge Behavioral Health Foundation, Inc.
ASSETS						
CURRENT ASSETS:						
Cash and cash equivalents	$ 1,600,410		$ 949,559	$ 181,280	$ 68,492	$ 401,079
Current portion pledges receivable, less allowance for doubtful pledges of $4,000	60,992		-	55,700	-	5,292
Contributions receivable	207,512		207,512	-	-	-
Prepaid expenses	9,396		-	-	9,100	296
TOTAL CURRENT ASSETS	1,878,310		1,157,071	236,980	77,592	406,667
CASH AND CASH EQUIVALENTS HELD FOR CAPITAL ACQUISITIONS	112,051		-	112,051	-	-
INVESTMENTS	1,164,775		545,630	619,145	-	-
BENEFICIAL INTEREST IN TRUSTS	586,476		-	586,476	-	-
NONCURRENT PORTION OF PLEDGES RECEIVABLE, LESS ALLOWANCE FOR DOUBTFUL PLEDGES OF $8,000	2,697,847		2,111,081	-	586,766	-
OTHER ASSETS	2,000		-	2,000	-	-
TOTAL	$ 6,441,459	$ -	$ 3,813,782	$ 1,556,652	$ 664,358	$ 406,667
LIABILITIES AND NET ASSETS						
CURRENT LIABILITIES:						
Accounts payable and accrued expenses	$ 9,025		$ -	$ -	$ 9,025	$ -
OTHER LIABILITIES:						
Liability to charitable gift annuitants	83,915		83,915	-	-	-
TOTAL LIABILITIES	92,940		83,915	-	9,025	-
NET ASSETS:						
Unrestricted	1,601,009		1,287,987	172,258	33,233	107,531
Temporarily restricted	4,747,510		2,441,880	1,384,394	622,100	299,136
TOTAL NET ASSETS	6,348,519		3,729,867	1,556,652	655,333	406,667
TOTAL	$ 6,441,459	$ -	$ 3,813,782	$ 1,556,652	$ 664,358	$ 406,667

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.

Foundations

Schedule of Combining Information, Statement of Operations
For the Year Ended December 31, 2008

	Combined Adventist HealthCare, Inc. Foundations	Eliminating Entries	Shady Grove Adventist Hospital Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Hackettstown Adventist Hospital Foundation, Inc.	Potomac Ridge Behavioral Health Foundation, Inc.
CHANGES IN UNRESTRICTED NET ASSETS:						
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT:						
Contributions, net	$ 326,177		$ 93,434	$ 115,825	$ -	$ 116,918
Investment (loss) income	(133,580)		(176,058)	31,648	(8,013)	18,843
Net assets released from restrictions	2,669,665		2,040,212	624,770	-	4,683
TOTAL UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT	2,862,262		1,957,588	772,243	(8,013)	140,444
EXPENSES:						
General administrative expenses	272,695		108,755	101,326	-	62,614
In-kind gifts expended	53,782		6,971	46,811	-	-
TOTAL EXPENSES BEFORE TRANSFERS TO THE HOSPITALS	326,477		115,726	148,137	-	62,614
Transfers to the hospital	2,682,445		2,024,127	653,635	-	4,683
TOTAL EXPENSES	3,008,922		2,139,853	801,772	-	67,297
REVENUES (LESS THAN) IN EXCESS OF EXPENSES	(146,660)		(182,265)	(29,529)	(8,013)	73,147
Change in net unrealized (loss) gains on investments other than trading securities	42,733		45,254	1,094	-	(3,615)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(103,927)		(137,011)	(28,435)	(8,013)	69,532
UNRESTRICTED NET ASSETS, BEGINNING	1,704,936		1,424,998	200,693	41,246	37,999
UNRESTRICTED NET ASSETS, ENDING	$ 1,601,009	$ -	$ 1,287,987	$ 172,258	$ 33,233	$ 107,531
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS:						
Contributions, net	$ 2,963,204		$ 2,353,969	$ 529,162	$ 15,561	$ 64,512
Change in value of beneficial interest in trusts	(125,062)		-	(125,062)	-	-
Change in discount of pledges receivable and provision for doubtful pledges	(982,622)		(979,828)	(2,794)	-	-
Investment income and unrealized gain on investments	(19,881)		(23,451)	-	-	3,570
Net assets released from restrictions	(2,669,665)		(2,040,212)	(624,770)	-	(4,683)
(DECREASE) INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	(834,026)		(689,522)	(223,464)	15,561	63,399
TEMPORARILY RESTRICTED NET ASSETS, BEGINNING	5,581,536		3,131,402	1,607,858	606,539	235,737
TEMPORARILY RESTRICTED NET ASSETS, ENDING	$ 4,747,510	$ -	$ 2,441,880	$ 1,384,394	$ 622,100	$ 299,136

See Notes to Consolidated Financial Statements

Adventist HealthCare, Inc.

Foundations

Schedule of Combining Information, Statements of Cash Flows

For the Year Ended December 31, 2008

	Combined Adventist HealthCare, Inc. Foundations	Eliminating Entries	Shady Grove Adventist Hospital Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Hackettstown Adventist Hospital Foundation, Inc.	Potomac Ridge Behavioral Health Foundation, Inc.
Cash flows from operating activities:						
(Decrease) increase in net assets	$ (937,953)	$ -	$ (826,533)	$ (251,899)	$ 7,548	$ 132,931
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:						
Contributions restricted for long-term purposes	(1,864,956)		(1,856,427)	(8,529)	-	-
Transfers to Hospitals	2,682,445		2,024,127	653,635	-	4,683
Provision for doubtful pledges	1,087,517		1,084,723	2,794	-	-
Net change in unrealized gains and losses on investments other than trading securities	(36,014)		(34,920)	(1,094)	-	-
Change in beneficial interest in trusts	125,062		-	125,062	-	-
Change in discount in pledges receivable	(104,895)		(104,895)	-	-	-
Change in assets and liabilities:	-					
Prepaid expense and other assets	23,093		-	(1,000)	4,750	19,343
Pledge receivable, net	(146,586)		(24,846)	5,856	(129,597)	2,001
Contributions receivable	(207,512)		(207,512)	-	-	-
Accounts payable and accrued expenses	(272)		-	-	(272)	
Liability to charitable gift annuitants	457		457	-	-	-
Net cash provided by (used in) operating activities	620,386		54,174	524,825	(117,571)	158,958
Cash flows from investing activities:						
Net decrease in investments	424,307		313,766	110,541	-	-
Net decrease in restricted cash	9,108		-	9,108	-	-
Transfers to Hospitals	(2,682,445)		(2,024,127)	(653,635)	-	(4,683)
Net cash used in investing activities	(2,249,030)		(1,710,361)	(533,986)	-	(4,683)
Cash flows provided by financing activities:						
Contributions restricted for long-term purposes	1,864,956		1,856,427	8,529	-	-
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	236,312		200,240	(632)	(117,571)	154,275
CASH AND CASH EQUIVALENTS, BEGINNIING	1,364,098		749,319	181,912	186,063	246,804
CASH AND CASH EQUIVALENTS, ENDING	$ 1,600,410	$ -	$ 949,559	$ 181,280	$ 68,492	$ 401,079

See Notes to Consolidated Financial Statements

Attachment 12

Cash flow projections

ADVENTIST HEALTHCARE INC.
Summary of Cash Flows Projection
2009 to 2012

	Consolidated	WAH	Clarksburg	Fairland	Rivermont	SGAH	ASLS	Others
Revenue in excess of (less than) expenses	$ 148,118	$ 36,734	$ (875)	$ -	$ (701)	$ 56,206	$ 14,063	$ 42,691
Adjustments:								
Depreciation and amortization	151,188	33,004	-	-	622	53,493	8,725	55,344
Changes in working capital	9,092	(3,343)	-	3,301	2,175	8,581	(615)	(1,007)
Others	4,057	589	-	(200)	-	1,999	38	1,631
Net cash provided by operating activities	312,455	66,984	(875)	3,101	2,096	120,279	22,211	98,659
Cash flows from investing activities:								
Additions to property, plant and equipment	(818,813)	(449,766)	(161,179)	(36,352)	(32,152)	(41,175)	(11,649)	(86,540)
Contribution from foundation and grant	43,139	28,139	15,000	-	-	-	-	-
Change in trustee held investments	(48,782)	(31,966)	(12,076)	(3,300)	(1,440)	-	-	-
Net cash provided by (used in) investing activities	(824,456)	(453,593)	(158,255)	(39,652)	(33,592)	(41,175)	(11,649)	(86,540)
Cash flows from financing activities:								
Repayments of long term debt principal	(76,605)	(14,358)	-	-	-	(14,953)	(2,605)	(44,689)
Proceeds from issuance of long term debt	639,867	415,540	159,135	34,042	29,000	2,000	-	150
Payments of issuance costs	(36,289)	(23,968)	(8,900)	(1,273)	(2,148)	-	-	-
Capital/loan from investors/AHC	-	36,656	28,020	3,782	5,300	-	(9,082)	(64,676)
Net cash provided by (used in) financing activities	526,973	413,870	178,255	36,551	32,152	(12,953)	(11,687)	(109,215)
Net increase in cash and cash equivalents	14,972	27,261	19,125	-	656	66,151	(1,125)	(97,096)
Cash and cash equivalent at beginning of year	153,788	9,312	-	-	-	15,598	14,556	114,322
Cash and cash equivalent at end of year	$ 168,760	$ 36,573	$ 19,125	$ -	$ 656	$ 81,749	$ 13,431	$ 17,226

Attachment 13

Attachment 1 of impact analysis

Medsurg

Zipc ode	HX	WAH	MGH	DCH	LRH	SH	PGMC SUBTOTAL		Other Md	TOTAL MD
20705	225	270	15	111	404	24	42	1,091	171	1,262
20712	47	210	1	49	3	12	73	395	33	428
20737	81	214	3	363	22	15	241	939	95	1,034
20740	120	383	7	339	76	29	69	1,023	159	1,182
20770	141	141	14	621	65	24	96	1,102	171	1,273
20782	173	929	6	188	26	19	102	1,443	105	1,548
20783	371	1,516	13	85	49	37	75	2,146	169	2,315
20866	187	101	80	11	105	25	9	518	137	655
20901	859	540	43	5	10	139	12	1,608	169	1,777
20902	1,447	290	139	20	13	323	13	2,245	224	2,469
20903	396	537	27	25	7	46	17	1,056	67	1,123
20904	1,715	656	303	46	303	224	23	3,270	341	3,611
20905	252	108	348	1	29	73	10	821	159	980
20906	1,386	277	2,560	18	18	533	17	4,809	559	5,368
20910	873	433	28	3	8	209	11	1,565	164	1,729
20912	244	1,072	11	28	9	45	13	1,422	85	1,507
Grand Total	**8,517**	**7,677**	**3,598**	**1,913**	**1,147**	**1,777**	**823**	**25,453**	**2,808**	**28,261**

Psychiatric

Zipc ode	WAH	MGH	PGMC	LRH	SH	HX	DCH	SUBTOTAL	Other Md	TOTAL MD
20705	17	5	1	32	2			57	6	63
20706	21	1	66	21		2	3	114	13	127
20707	12	4	13	92	3			124	17	141
20710	5		19	2			1	27	4	31
20712	24		8	1	3			36	-	36
20723	3	3	4	27	1			38	51	89
20737	29		27	6			3	65	5	70
20740	29	2	22	4	2			59	14	73
20770	31	2	27	20	7	2	2	91	10	101
20782	40	3	17		3	1	1	65	5	70
20783	77	6	13	4	2	2		104	6	110
20784	22	3	58	8	3		4	98	13	111
20832	5	89	1		10	1		106	4	110
20853	15	65	1	1	15	1	1	99	5	104
20860		13		1				14	-	14
20866	9	6	1	8	4	1		29	11	40
20868	1	2			1			4	-	4
20901	78	25			14	3		120	6	126
20902	81	45	1	1	30	3		161	7	168
20903	59	10	3	2	4		1	79	3	82
20904	88	63	3	19	21	4		198	8	206
20905	10	43		2	1			56	2	58
20906	64	176	4	1	46	7		298	11	309
20910	120	15		1	44	8		188	6	194
20912	194	3	2		8	1		208	3	211
Grand Total	**1034**	**584**	**291**	**253**	**224**	**36**	**16**	**2438**	**210**	**2,648**

Obstetrics

Zipc ode	HX	WAH	PGHC	LRH	MGH	DCH	SH SUBTOTAL	Other Md	TOTAL MD
20011	49	13	5	1			68	17	85
20705	180	54	33	38	2	1	308	27	335
20706	201	85	190	32	4	11	523	52	575
20707	221	43	28	101	7	0	400	133	533
20712	26	18	36	5	1		86	6	92
20723	120	17	1	15	3	0	0 156	311	467
20737	98	50	182	22	1	10	363	23	386
20740	95	32	31	19	2	2	181	45	226
20759	3	0	0		1		4	24	28
20782	146	100	70	8		1	325	21	346
20783	208	177	126	25	3		539	17	556
20901	400	175	3	2	8		1 589	38	627
20902	582	183	2		22		789	75	864
20903	264	206	10	4	8		492	25	517
20904	482	180	4	11	28		2 707	80	787
20906	595	202	1	4	91		893	130	1,023
20912	187	176	9	4	3		379	16	395
Grand Total	**3,857**	**1,711**	**731**	**291**	**184**	**25**	**3 6,802**	**1,040**	**7,842**

Medsurg

TP SHARE	Total	WO Share	Total	WAH Share	Total
21.4%	78.6%	30.0%	70.0%	379	883
49.1%	50.9%	5.0%	95.0%	21	407
20.7%	79.3%	10.0%	90.0%	103	931
32.4%	67.6%	33.0%	67.0%	390	792
11.1%	88.9%	10.0%	90.0%	127	1,146
60.0%	40.0%	50.0%	50.0%	774	774
65.5%	34.5%	50.0%	50.0%	1,158	1,158
15.4%	84.6%	40.0%	60.0%	262	393
30.4%	69.6%	40.0%	60.0%	711	1,066
11.7%	88.3%	15.0%	85.0%	370	2,099
47.8%	52.2%	50.0%	50.0%	562	562
18.2%	81.8%	50.0%	50.0%	1,806	1,806
11.0%	89.0%	40.0%	60.0%	392	588
5.2%	94.8%	10.0%	90.0%	537	4,831
25.0%	75.0%	15.0%	85.0%	259	1,470
71.1%	28.9%	50.0%	50.0%	754	754
				8,604	**19,657**

Psychiatric

TP SHARE	Total	WO Share	Total	WAH Share	Total
27.0%	73.0%	30.0%	70.0%	19	44
16.5%	83.5%	15.0%	85.0%	19	108
8.5%	91.5%	5.0%	95.0%	7	134
16.1%	83.9%	15.0%	85.0%	5	26
66.7%	33.3%	55.0%	45.0%	20	16
3.4%	96.6%	4.0%	96.0%	4	85
41.4%	58.6%	35.0%	65.0%	25	46
39.7%	60.3%	33.0%	67.0%	24	49
30.7%	69.3%	30.0%	70.0%	30	71
57.1%	42.9%	50.0%	50.0%	35	35
70.0%	30.0%	50.0%	50.0%	55	55
19.8%	80.2%	12.0%	88.0%	13	98
4.5%	95.5%	5.0%	95.0%	6	105
14.4%	85.6%	10.0%	90.0%	10	94
0.0%	100.0%	10.0%	90.0%	1	13
22.5%	77.5%	15.0%	85.0%	6	34
25.0%	75.0%	25.0%	75.0%	1	3
61.9%	38.1%	65.0%	35.0%	82	44
48.2%	51.8%	55.0%	45.0%	92	76
72.0%	28.0%	75.0%	25.0%	62	21
42.7%	57.3%	55.0%	45.0%	113	93
17.2%	82.8%	35.0%	65.0%	20	38
20.7%	79.3%	45.0%	55.0%	139	170
61.9%	38.1%	50.0%	50.0%	97	97
91.9%	8.1%	80.0%	20.0%	169	42
				1,054	**1594**

Obstetrics

TP SHARE	Total	WO Share	Total	WAH Share	Total
15.3%	84.7%	5.0%	95.0%	4	81
16.1%	83.9%	30.0%	70.0%	101	235
14.8%	85.2%	5.0%	95.0%	29	546
8.1%	91.9%	50.0%	50.0%	267	267
19.6%	80.4%	5.0%	95.0%	5	87
3.6%	96.4%	15.0%	85.0%	70	397
13.0%	87.0%	10.0%	90.0%	39	347
14.2%	85.8%	33.0%	67.0%	75	151
0.0%	100.0%	33.0%	67.0%	9	19
28.9%	71.1%	50.0%	50.0%	173	173
31.8%	68.2%	50.0%	50.0%	278	278
27.9%	72.1%	40.0%	60.0%	251	376
21.2%	78.8%	15.0%	85.0%	130	734
39.8%	60.2%	50.0%	50.0%	259	259
22.9%	77.1%	50.0%	50.0%	394	394
19.7%	80.3%	10.0%	90.0%	102	921
44.6%	55.4%	50.0%	50.0%	198	198
				2,380	**5,462**

Medsurg

% Allocation of total Discharges

HX	WAH	MGH	DCH	LRH	SH	PGMC	Other Md
22.68%		1.5%	11.2%	40.7%	2.4%	4.2%	17.24%
21.56%		0.5%	22.5%	1.4%	5.5%	33.5%	15.14%
9.88%		0.4%	44.3%	2.7%	1.8%	29.4%	11.59%
15.02%		0.9%	42.4%	9.5%	3.6%	8.6%	19.90%
12.46%		1.2%	54.9%	5.7%	2.1%	8.5%	15.11%
27.95%		1.0%	30.4%	4.2%	3.1%	16.5%	16.96%
46.43%		1.6%	10.6%	6.1%	4.6%	9.4%	21.15%
33.75%		14.4%	2.0%	19.0%	4.5%	1.6%	24.73%
69.44%		3.5%	0.4%	0.8%	11.2%	1.0%	13.66%
66.41%		6.4%	0.9%	0.6%	14.8%	0.6%	10.28%
67.58%		4.6%	4.3%	1.2%	7.8%	2.9%	11.43%
58.04%		10.3%	1.6%	10.3%	7.6%	0.8%	11.54%
28.90%		39.9%	0.1%	3.3%	8.4%	1.1%	18.23%
27.22%		50.3%	0.4%	0.4%	10.5%	0.3%	10.98%
67.36%		2.2%	0.2%	0.6%	16.1%	0.8%	12.65%
56.09%		2.5%	6.4%	2.1%	10.3%	3.0%	19.54%

Psychiatric

% Allocation of total Discharges

WAH	MGH	PGMC	LRH	SH	HX	DCH	Other Md
	10.9%	2.2%	69.6%	4.3%	0.0%	0.0%	13.04%
	0.9%	62.3%	19.8%	0.0%	1.9%	2.8%	12.26%
	3.1%	10.1%	71.3%	2.3%	0.0%	0.0%	13.18%
	0.0%	73.1%	7.7%	0.0%	0.0%	3.8%	15.38%
	0.0%	66.7%	8.3%	25.0%	0.0%	0.0%	0.00%
	3.5%	4.7%	31.4%	1.2%	0.0%	0.0%	59.30%
	0.0%	65.9%	14.6%	0.0%	0.0%	7.3%	12.20%
	4.5%	50.0%	9.1%	4.5%	0.0%	0.0%	31.82%
	2.9%	38.6%	28.6%	10.0%	2.9%	2.9%	14.29%
	10.0%	56.7%	0.0%	10.0%	3.3%	3.3%	16.67%
	18.2%	39.4%	12.1%	6.1%	6.1%	0.0%	18.18%
	3.4%	65.2%	9.0%	3.4%	0.0%	4.5%	14.61%
	84.8%	1.0%	0.0%	9.5%	1.0%	0.0%	3.81%
	73.0%	1.1%	1.1%	16.9%	1.1%	1.1%	5.62%
	92.9%	0.0%	7.1%	0.0%	0.0%	0.0%	0.00%
	19.4%	3.2%	25.8%	12.9%	3.2%	0.0%	35.48%
	66.7%	0.0%	0.0%	33.3%	0.0%	0.0%	0.00%
	52.1%	0.0%	0.0%	29.2%	6.3%	0.0%	12.50%
	51.7%	1.1%	1.1%	34.5%	3.4%	0.0%	8.05%
	43.5%	13.0%	8.7%	17.4%	0.0%	4.3%	13.04%
	53.4%	2.5%	16.1%	17.8%	3.4%	0.0%	6.78%
	89.6%	0.0%	4.2%	2.1%	0.0%	0.0%	4.17%
	71.8%	1.6%	0.4%	18.8%	2.9%	0.0%	4.49%
	20.3%	0.0%	1.4%	59.5%	10.8%	0.0%	8.11%
	17.6%	11.8%	0.0%	47.1%	5.9%	0.0%	17.65%

Obstetrics

% Allocation of total Discharges

HX	WAH	PRMC	LRH	MGH	DCH	SH	Other Md
68.06%		6.9%	1.4%	0.0%	0.0%	0.0%	23.61%
64.06%		11.7%	13.5%	0.7%	0.4%	0.0%	9.61%
41.02%		38.8%	6.5%	0.8%	2.2%	0.0%	10.61%
45.10%		5.7%	20.6%	1.4%	0.0%	0.0%	27.14%
35.14%		48.6%	6.8%	1.4%	0.0%	0.0%	8.11%
26.67%		0.2%	3.3%	0.7%	0.0%	0.0%	69.11%
29.17%		54.2%	6.5%	0.3%	3.0%	0.0%	6.85%
48.97%		16.0%	9.8%	1.0%	1.0%	0.0%	23.20%
10.71%		0.0%	0.0%	3.6%	0.0%	0.0%	85.71%
59.35%		28.5%	3.3%	0.0%	0.4%	0.0%	8.54%
54.88%		33.2%	6.6%	0.8%	0.0%	0.0%	4.49%
88.50%		0.7%	0.4%	1.8%	0.0%	0.2%	8.41%
85.46%		0.3%	0.0%	3.2%	0.0%	0.0%	11.01%
84.89%		3.2%	1.3%	2.6%	0.0%	0.0%	8.04%
79.41%		0.7%	1.8%	4.6%	0.0%	0.3%	13.18%
72.47%		0.1%	0.5%	11.1%	0.0%	0.0%	15.83%
85.39%		4.1%	1.8%	1.4%	0.0%	0.0%	7.31%

Medsurg

HX	WAH	MGH	DCH	LRH	SH	PGMC	Other Md	TOTAL MD
200	379	13	99	360	21	37	152	1,262
88	21	2	91	6	22	136	62	428
92	103	3	412	25	17	274	108	1,034
119	390	7	336	75	29	68	158	1,182
143	127	14	629	66	24	97	173	1,273
216	774	8	235	33	24	128	131	1,548
537	1,158	19	123	71	54	109	245	2,315
133	262	57	8	74	18	6	97	655
740	711	37	4	9	120	10	146	1,777
1,394	370	134	19	13	311	13	216	2,469
379	562	26	24	7	44	16	64	1,122
1,048	1,806	185	28	185	137	14	208	3,611
170	392	235	1	20	49	7	107	980
1,315	537	2,429	17	17	506	16	530	5,368
990	259	32	3	9	237	12	186	1,729
423	754	19	49	16	78	23	147	1,507
7,987	**8,604**	**3,220**	**2,078**	**984**	**1,691**	**966**	**2,730**	**28,260**

Psychiatric

WAH	MGH	PGMC	LRH	SH	HX	DCH	Other Md	TOTAL MD
19	5	1	31	2	0	0	6	63
19	1	67	21	0	2	3	13	127
7	4	13	96	3	0	0	18	141
5	0	19	2	0	0	1	4	31
20	0	11	1	4	0	0	0	36
4	3	4	27	1	0	0	51	89
25	0	30	7	0	0	3	6	70
24	2	24	4	2	0	0	16	73
30	2	27	20	7	2	2	10	101
35	4	20	0	4	1	1	6	70
55	10	22	7	3	3	0	10	110
13	3	64	9	3	0	4	14	111
6	89	1	0	10	1	0	4	110
10	68	1	1	16	1	1	5	104
1	12	0	1	0	0	0	0	14
6	7	1	9	4	1	0	12	40
1	2	0	0	1	0	0	0	4
82	23	0	0	13	3	0	6	126
92	39	1	1	26	3	0	6	168
62	9	3	2	4	0	1	3	82
113	49	2	15	16	3	0	6	206
20	34	0	2	1	0	0	2	58
139	122	3	1	32	5	0	8	309
97	20	0	1	58	10	0	8	194
169	7	5	0	20	2	0	7	211
1,054	**515**	**319**	**256**	**230**	**38**	**17**	**219**	**2,648**

Obstetrics

HX	WAH	PRMC	LRH	MGH	DCH	SH	Other Md	TOTAL MD
55	4	6	1	0	0	0	19	85
150	101	28	32	2	1	0	23	335
224	29	212	36	4	12	0	58	575
120	267	15	55	4	0	0	72	533
31	5	43	6	1	0	0	7	92
106	70	1	13	3	0	0	274	467
101	39	188	23	1	10	0	24	386
74	75	24	15	2	2	0	35	226
2	9	0	0	1	0	0	16	28
103	173	49	6	0	1	0	15	346
153	278	92	18	2	0	0	12	556
333	251	2	2	7	0	1	32	627
628	130	2	0	24	0	0	81	864
219	259	8	3	7	0	0	21	517
312	394	3	7	18	0	1	52	787
667	102	1	4	102	0	0	146	1,023
169	198	8	4	3	0	0	14	395
3,447	**2,380**	**682**	**224**	**179**	**26**	**2**	**901**	**7,842**

Attachment 14

Attachment 2 of impact analysis

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	7,909	26.4%	8,917	25.0%
HX	8,524	28.5%	10,216	28.7%
DCH	3,337	11.2%	4,043	11.4%
MGH	3,185	10.6%	3,862	10.8%
SH	1,747	5.8%	2,150	6.0%
PGHC	1,213	4.1%	1,515	4.3%
LRH	1,099	3.7%	1,379	3.9%
Other Md.	2,895	9.7%	3,517	9.9%
TOTAL	29,909	100.0%	35,599	100.0%
			35,597	

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH TP PSA

MSGA TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	7,909	26.4%	8,564	24.1%	7.65%
HX	8,524	28.5%	10,266	28.8%	16.97%
DCH	3,337	11.2%	4,093	11.5%	18.46%
MGH	3,185	10.6%	3,912	11.0%	18.58%
SH	1,747	5.8%	2,200	6.2%	20.60%
PGHC	1,213	4.1%	1,565	4.4%	22.48%
LRH	1,099	3.7%	1,429	4.0%	23.09%
Other Md.	2,895	9.7%	3,567	10.0%	18.83%
TOTAL	29,909	100.0%	35,595	100.0%	15.97%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	7,909	8114	205	2.59%
HX	8,524	8252	-272	-3.19%
DCH	3,337	3551	214	6.41%
MGH	3,185	2949	-236	-7.41%
SH	1,747	1712	-35	-2.00%
PGHC	1,213	1387	174	14.34%
LRH	1,099	983	-116	-10.56%
Other Md.	2,895	2961	66	2.28%
TOTAL	29,909	29,909	0	0.00%

Forecasted Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH TP PSA

OB TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	1,808	6.0%	1,958	23.6%	7.66%
HX	3,953	13.2%	4,323	52.2%	8.56%
DCH	33	0.1%	36	0.4%	8.33%
MGH	176	0.6%	191	2.3%	7.85%
SH	4	0.0%	4	0.0%	0.00%
PGHC	777	2.6%	841	10.2%	7.61%
LRH	196	0.7%	212	2.6%	7.55%
Other Md.	665	2.2%	715	8.6%	6.99%
TOTAL	7,612	25.5%	8,280	100.0%	8.07%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,808	2,135	327	18.09%
HX	3,953	3,693	-260	-6.58%
DCH	33	35	2	6.06%
MGH	176	175	-1	-0.57%
SH	4	3	-1	-25.00%
PGHC	777	751	-26	-3.35%
LRH	196	180	-16	-8.16%
Other Md.	665	640	-25	-3.76%
TOTAL	7,612	7,612	0	0.00%

Forecasted Utilization of WAH Hospital and Impact on
Other Maryland Hospitals: WAH TP PSA

PSCH TP PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share	% change
WAH	1,059	3.5%	1,124	38.9%	5.78%
HX	37	0.1%	40	1.4%	7.50%
DCH	16	0.1%	16	0.6%	0.00%
MGH	587	2.0%	636	22.0%	7.70%
SH	230	0.8%	249	8.6%	7.63%
PGHC	293	1.0%	317	11.0%	7.57%
LRH	253	0.8%	274	9.5%	7.66%
Other Md.	216	0.7%	234	8.1%	7.69%
TOTAL	2,691	9.0%	2,890	100.0%	6.89%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,059	1,071	12	1.13%
HX	37	39	2	5.41%
DCH	16	17	1	6.25%
MGH	587	520	-67	-11.41%
SH	230	238	8	3.48%
PGHC	293	322	29	9.90%
LRH	253	256	3	1.19%
Other Md.	216	228	12	5.56%
TOTAL	2,691	2,691	0	0.00%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

MSGA WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	7,677	27.2%	8,264	25.2%
HX	8,517	30.1%	9,962	30.4%
DCH	1,913	6.8%	2,266	6.9%
MGH	3,598	12.7%	4,266	13.0%
SH	1,777	6.3%	2,143	6.5%
PGHC	823	2.9%	1,008	3.1%
LRH	1,147	4.1%	1,412	4.3%
Other Md.	2,808	9.9%	3,337	10.2%
TOTAL	28,260	100.0%	32,774	100.0%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	7,677	8604	927	12.08%
HX	8,517	7987	-530	-6.22%
DCH	1,913	2078	165	8.63%
MGH	3,598	3220	-378	-10.51%
SH	1,777	1691	-86	-4.84%
PGHC	823	966	143	17.38%
LRH	1,147	984	-163	-14.21%
Other Md.	2,808	2730	-78	-2.78%
TOTAL	28,260	28,260	0	0.00%

MSGA WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	8,604	30.4%	9,262	28.3%
HX	7,987	28.3%	9,342	28.5%
DCH	2,078	7.4%	2,462	7.5%
MGH	3,220	11.4%	3,818	11.7%
SH	1,691	6.0%	2,039	6.2%
PGHC	966	3.4%	1,183	3.6%
LRH	984	3.5%	1,211	3.7%
Other Md.	2,730	9.7%	3,244	9.9%
TOTAL	28,260	100.0%	32,774	100.0%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

OB	WO PSA			
Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,711	21.8%	1,842	5.6%
HX	3,857	49.2%	4,187	12.8%
DCH	25	0.3%	27	0.1%
MGH	184	2.3%	198	0.6%
SH	3	0.0%	3	0.0%
PGHC	731	9.3%	787	2.4%
LRH	291	3.7%	313	1.0%
Other Md.	1,040	13.3%	1,113	3.4%
TOTAL	7,842	100.0%	8,475	25.9%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,711	2,380	669	39.10%
HX	3,857	3,448	-409	-10.60%
DCH	25	26	1	4.00%
MGH	184	179	-5	-2.72%
SH	3	2	-1	-33.33%
PGHC	731	682	-49	-6.70%
LRH	291	224	-67	-23.02%
Other Md.	1,040	901	-139	-13.37%
TOTAL	7,842	7,842	0	0.00%

OB	WO PSA			
Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	2,380	30.3%	2,562	7.8%
HX	3,447	44.0%	3,742	11.4%
DCH	26	0.3%	28	0.1%
MGH	179	2.3%	193	0.6%
SH	2	0.0%	2	0.0%
PGHC	682	8.7%	734	2.2%
LRH	224	2.9%	241	0.7%
Other Md.	901	11.5%	964	2.9%
TOTAL	7,841	100.0%	8,474	25.9%

Forecasted Utilization of WAH Hospital and Impact on Other Maryland Hospitals: WAH WO PSA

PSCH WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,034	3.7%	1,094	3.3%
HX	36	0.1%	39	0.1%
DCH	16	0.1%	16	0.0%
MGH	584	2.1%	629	1.9%
SH	224	0.8%	241	0.7%
PGHC	291	1.0%	313	1.0%
LRH	253	0.9%	272	0.8%
Other Md.	210	0.7%	226	0.7%
TOTAL	2,648	9.4%	2,830	8.6%

PSCH WO PSA

Hospital	FY 2008	Market Share	FY 2016	Market Share
WAH	1,054	3.7%	1,115	3.4%
HX	38	0.1%	41	0.1%
DCH	16	0.1%	16	0.0%
MGH	516	1.8%	556	1.7%
SH	230	0.8%	248	0.8%
PGHC	319	1.1%	343	1.0%
LRH	256	0.9%	276	0.8%
Other Md.	219	0.8%	236	0.7%
TOTAL	2,648	9.4%	2,830	8.6%

Hospital	TP Share	WO Share	(Loss/Gain)	% change
WAH	1,034	1,054	20	1.93%
HX	36	38	2	5.56%
DCH	16	16	0	0.00%
MGH	584	516	-68	-11.64%
SH	224	230	6	2.68%
PGHC	291	319	28	9.62%
LRH	253	256	3	1.19%
Other Md.	210	219	9	4.29%
TOTAL	2,648	2,648	0	0.00%

Attachment 15
A detailed list of the extraordinary cost items excluded from the MVS analysis with explanations

Washington Adventist Hospital Replacement Hospital
Certificate of Need Documentation - Extraordinary Cost Adjustments

Key: ACB = Ambulatory Care Building
WAH = Washington Adventist Hospital
WAH CON = Rich Coughlan
LSA = Loiederman Soltesz Associates (Civil Enginner)
PR = Parker Rodriguez (Landscape Architect)

Extraordinary Cost	Description	Scope	Estmate value for Hospital/Faith Center/Parking Structures
Site:			
Deforestation - Tree Clearing	The site is totally wooded and needs to be cleared and grubbed before any development can occur.	Estimate the cost to clear and grub the site.	$136,000
Site Grading	Due to the steepness of the existing site, significant amounts of fill and Earthwork are needed to establish the building pads.	Provide a cost differential between what earthwork is needed to create the building pads (for the Main Hospital, Ambulatory care Building (ACB), North & South Garages) and what additional earthwork is required to make the site function outside of those building pads. Include any costs to prepare the base building pads that are in excess of what would normally be required to prepare the building pads due to special conditions of the site, construction, etc.	$400,540
Site Retaining Walls	Significant retaining walls of extraordinary height are needed on site to establish the building pads due to the steep site topography.	Quantify all site retaining walls. Exclude retaining walls associated with helipad construction.	$314,500
Existing Site Utility Relocatior	Since the site is not a greenfield site, the 2 existing storm water lines and sewer line traversing the site must be relocated to accommodate the building footprints and site plan.	Provide the cost necessary to move and relocate the 2 exisiting storm water lines and the existing sanitary sewer.	$106,600
Storm Drainage	Storm drain infrastructure must be implemented on site as the existing site does not contain storm drainage.	Provide all costs associated with installing the storm drainage system on the site.	$916,600
Wetlands & Tree Save Protec	Due to various environmental buffers on site and the presence of wetlands and designated tree save areas to fulfill county requirements, measures must be taken to protect these areas during construction.	Estimate the cost for standard methods of protection.	$34,700
Forest Conservation	Montgomery County requires forest conservation measures to replace trees that are removed from the site due to construction. Since the site is completely wooded, the amount of forest conservation required is extraordinary.	Estimate cost to reforest 4.3 acres, 0.84 acres of which are on-site, the remaining balance to be off-site at a 1:1 - 2:1 ration depending upon the selected method appropriate for the designated off-site locations. Include cost of required 2yr bonding for the cost of the plantings, installation, and maintenance. Estimate the wetlands enhancement requirement of 0.48 acres.	$340,000
Sediment Control & Stabilizat	Significant measures are needed due to the large volume of Earthwork and site work being performed.	Estimate the cost associated with all Sediment control and stabilization in accordance with the Erosion and Sediment Control Concept Plan drawings.	$107,300

Way finding Signage	Costs for sufficient site way finding signage to direct traffic on the new hospital campus.	Provide an estimate for all way-finding signage on the site. Reference attached drawings.	$125,000
Ground Helipad	Helicopter landing pads are not required in typical hospital construction.	Provide construction costs for the ground helipad, including necessary lighting, roof windsock, retaining walls, and 3 security barricades along the loading dock access road and the entry to the ambulance drop-off and helipad.	$220,700
Site Improvements	Yard improvement costs for hardscape paving, furniture, and flagpoles.	Specific hardscape elements to include: 1. County requested six foot width county requested sidewalks (five foot typical) 2. All hardscape between the South Garage and the ACB and main building 3. The faith center/MOB 1 plaza at Private Street B as requested by the county 4. County requested access to the lake 5. Exterior terraces in healing garden/pathways 6. Lake trail system 7. County requested decorative paving at the main entry 8. Staff pathway from the North Garage 9. Healing Garden/Lake/Plaza furniture, pavilions 10. 3 flagpoles 11. Special features (water feature, special entrance feature/plaza)	$650,550
Landscaping	Yard improvements costs for grass, shrubs, plantings and trees. The site has over 2 acres of healing gardens and pathways and is planned for significant community amenities around the lake. The county requires significant landscape screening for parking structures and building service areas.	Specific landscape elements to include: 1. All trees and plants for healing gardens 2. All trees required for the Montgomery County Street Tree Panels 3. Addt'l screening for the parking garages per the County (incl. green screen planting) 4. Trees and plantings between the ACB and Main Building 5. All landscaping associated with the lake amenities 6. Loading dock landscape screening 7. Oxygen farm landscape screening 8. Landscape screening for transformers	$276,760
Oxygen Farm	The oxygen farm is located at some distance from the main hospital due to site restrictions and oxygen tank location requirements.	Retaining wall accounted for in "Site Retaining Walls." Fill accounted for with "Site Grading." Provide cost of approximate 500' distance of piping to main hospital for oxygen distribution.	$275,000

Off-Site:			
Roadway Relocation/Improve	Montgomery County DPWT has required several off site intersection improvements to accommodate the traffic being produced by the hospital relocation. Roadway improvements include paving, turn lanes, signalization, and pedestrian controls.	Per Traffic Group's Estimate, there are 4 intersection improvements consisting of signalization modifications and road improvements of various degree: Cherry Hill & Prosperity; Cherry Hill & Broadbirch; Cherry Hill & Plum Orchard; Plum Orchard & Private Street A. See the "Off-site Improvements" tab of this worksheet for estimates provided by the Traffic Group. An overall estimate of $2,675,000 is allocated for road improvements only.	$2,569,700
Utility Relocation	To accommodate expanding pavement areas and a bus drop off center, public utilities must be relocated.	The survey of the existing utilities to be relocated is not complete, but it is not unreasonable to expect 1,500 lf of existing electrical, water, or gas lines to need relocation. LSA estimate of 1,500lf @ 25 $/lf = $37,500+	
Right of Way/Easement Purcl	To accommodate expanded roadway paving, surface areas will extend into right of ways and utility easements. Negotiations with property owners and utility companies may require costs to achieve these improvements.	There are two intersections that may require ROW/easement purchase: Cherry Hill & Broadbirch (19,200sf); Cherry Hill & Plum Orchard (50,400sf). Per Traffic Group, off-site ROW and easement procurement from property owners were estimated at $15/SF. Though a cost has been allocated, no negotiation have occurred and WAH is hopeful purchasing may not be necessary. Estimate to purchase is kept as a placeholder. See the "Off-site Improvements" tab of this worksheet for estimates provided by the Traffic Group.	
Landscaping/Engineering	Re-landscaping of public streets is required to accommodate the roadway improvements. In some cases, retaining walls are required to achieve necessary grading as a result of improvements. Storm water management and sediment control will need to be included as part of the construction.	Storm Water Management: Given the long linear nature of the project, treatment will have to be done inside the road right way and would need be contained at the 13+ points. Treatment would most likely consist of a flow splitter ($6,500), a proprietary pretreatment device ($10,000), and a flow base water quantity treatment structure ($35,000). 13 x (6,500 + 10,000 + 35,000) = $663,000+. Sediment Control: It is assumed only silt fencing will be required along both sides of the 8,300 ft. of roadway improvement. 2 x 8,300 @ 8 $/LF = $132,800+. Grading: 80,000 sy grading outside ROW to return to existing grades = $102,400+ 80,000 sy @ $0.66 sy rough grading = $52,800+ 80,000 sy @ $0.62 sy fine grading = $49,600+ Retaining Walls: 1,200 square feet of retaining wall @ 100 $/sf = $120,000+ Trees: 298 trees @ $500 = $149,000 Shrubs: 250 shrubs@ $ 50 = $12,500 Seeding Allowance: $8,000 Sidewalks: 5' sidewalk 3,160lf @ $25/lf = $70,000 8' trail (asphalt)2,020lf @ $20/lf = $40,400 Estimates prepared by Parker Rodriguez and LSA. Some of this work is currently being surveyed and updated estimates may be available shortly.	
Main Hospital Basement:			
Hillside Foundation	Due to the steep existing grade, the hospital basement foundation walls are taller than a typical basement as the basement elevation is based upon limiting cut and fill on the site.	Provide the cost difference between a base case of 15'-0" high walls at 12" thickness vs. 21'-0" walls at 16" thickness for 807LF of foundation walls, and 12" thickness for remaining walls of the Main Building.	$254,000

Main Hospital (Levels 1-6):			
Pneumatic Tube System	Pneumatic Tube systems are not required in hospitals.	RTKL estimates 15 stations in the building. (1 each in central sterile, pharmacy, lab, pat test, surgery, IMCU, med surg units (3), ante/post parteum, ob) (2 each in ICU, ED)	$616,000
Synchronized Clock System	Part of building automated system to control all clocks in the hospital.	Estimate the cost of the building synchronized clock system ($277,038 according to Turner's 10/9/08 estimate)	$120,000
Infection Control	Measures such as adding additional hand washing stations are being incorporated into the design for increased and enhanced infection control.	Estimate the cost to include UV Light Sterilization as part of the AHU assemblies.	$190,000
High Rise Structure	Due to the site restrictions, the hospital floor plate is limited in size, forcing the additional of several levels that push the building into a high-rise designation.	Provide a cost estimate to include the following: - stairwell pressurization for stairwells over 75' in height - two-way stairway communications systems - fire pump for standpipe/sprinkler requirements - generator capacity and separate utility service for fire pump power - fire fighter communication systems in all stairways - fire alarm requirements for high-rise structures - building purge control by air handling units	$835,000
Planetree/ Evidence-Based D	Planetree design requires increased square footage to provide for education and family designated areas.	RTKL estimates that 9,524 sf can be attributed to Planetree design. See breakdown of spaces attributed to Planetree in "Planetree" tab.	$2,381,000
Network Protected Normal Power Switchgear	PEPCO requires network protected normal power switchgear to evenly distribute building load across each of the utility feeders from the utility company.	Provide a cost for spot network substation.	$12,000
Additional Elevators	Additional elevators in the current plans can be described as follows: (1) kitchen elevator to bring food to the servery from the basement kitchen (1) dedicated patient transport elevator in the North wing (2) elevators to service surgery from central sterile in the basement	<u>Include the following to establish cost:</u> 1. (1) Dedicated patient transfer elevator in the North wing 2. (1) Kitchen elevator to the servery 3. (2) elevators to service surgery from central sterile	$1,095,000

Sunken Garden	The sunken garden is designed to provide light into the Oncology Department and to provide Oncology patients with a more pleasant setting for treatment.	Provide an estimate for the sunken garden, complete with costs for façade treatment into the garden and with all landscape and hardscape as currently designed.	$500,000
Sustainability:			
LEED Certification	By statute, all new construction in Montgomery County must attain a minimum LEED Certified rating. In order to achieve this certification, costs above and beyond traditional hospital construction are necessary.	Provide a cost estimate to include the following: 1. Bioretention landscape construction 2. Cisterns in the North and South garages 3. Energy Recovery Units 4. Fundamental Building commissioning (CxA fees and energy model) 5. Enhanced building commissioning (contractor and CxA fees) 6. Construction Waste Management (contractor fees) 7. Registration ($450.00 USGBC flat fee) 8. Documentation (A/E fee) 9. Certification ($22,500 USGBC flat fee) 10. Contractor fees (General Requirements) 11. Cost of dual-flush and low flow fixtures vs. traditional fixtures 12. Cost of larger ductwork and more efficient custom AHU's vs. standard units 13. Cost of Transportation Management Plan Innovation point 14. Cost of Mechanical Penthouse	$2,211,500
Property Development:			
Montgomery County Land Us	WAH has undergone two processes to gain approvals to build the new campus on this site. Because Montgomery County has no official zoning for hospitals, a Special Exceptions approval was required by the Board of Appeals to approve the property use. In addition, because hospitals are not defined in the zoning ordinance, WAH had to also seek Site Plan approval in a second application. Any changes to the project to completion also requires amendments to these approved applications.	**WAH input needed on costs incurred as part of this process.**	$2,426,240
Design/Consultant associated with the above Land use approval	WAH has undergone two processes to gain approvals to build the new campus on this site. Because Montgomery County has no official zoning for hospitals, a Special Exceptions approval was required by the Board of Appeals to approve the property use. In addition, because hospitals are not defined in the zoning ordinance, WAH had to also seek Site Plan approval in a second application. Any changes to the project to completion also requires amendments to these approved applications.	**WAH input needed on costs incurred as part of this process.**	$544,000
		Total	$17,659,995